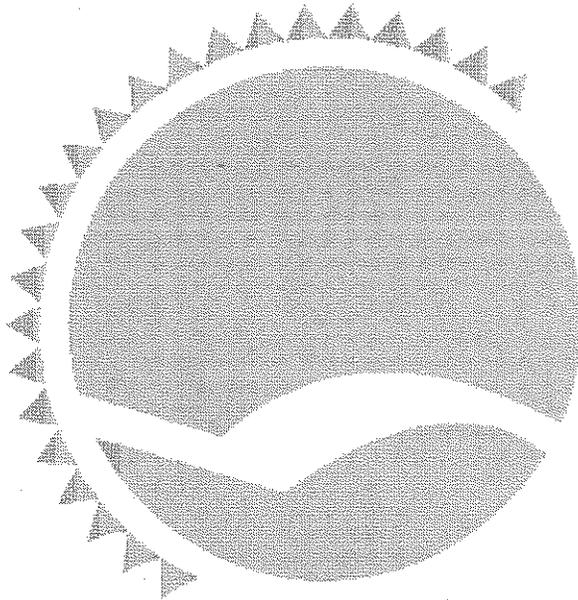

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

April 11, 2006



CONDENSED TRANSCRIPT AND CONCORDANCE
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ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 1

IN THE COURT OF COMMON PLEAS
CIVIL DIVISION
CUYAHOGA COUNTY, OHIO
CAUSE NO. 2005-CV564503

LYNN KEATING, ET AL)
VS.)
MICHAEL MAKII, M.D.)

VIDEO CONFERENCE ORAL DEPOSITION OF
PHILIPPE E. ZIMMERN, M.D.
APRIL 11, 2006

Reported By: Dawn M. Green
Job #57036

Page 3

1 VIDEO CONFERENCE ORAL DEPOSITION OF PHILIPPE E.
2 ZIMMERN, M.D., produced as a witness at the instance
3 of the PLAINTIFFS, and duly sworn, was taken in the
4 above-styled and numbered cause on APRIL 11, 2006,
5 from 7:00 p.m. to 8:30 p.m., before Dawn M. Green,
6 CSR in and for the State of Texas, reported by
7 machine shorthand, at the University of Texas
8 Southwestern Medical Center Department of Urology,
9 5323 Harry Hines Boulevard, Dallas, Texas, pursuant
10 to the Ohio Rules of Civil Procedure and the
11 provisions stated on the record or attached hereto.

A P P E A R A N C E S

14 FOR THE PLAINTIFFS:

15 Ms. Donna Taylor-Kolis
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Page 2

I N D E X

1
2
3 Page
4 Appearances: 3
5 Preliminary Proceedings 4
6 Examination by Ms. Donna Taylor-Kolis 4
7 7:01 p.m. - 8:30 p.m.
8 Reporter's Certification 76
9 * * * * *
10 EXHIBIT INDEX

11 Number Description Page Marked
12 1 Handwritten notes 9
13
14
15
16
17
18
19
20
21
22
23
24
25

Page 4

P R E L I M I N A R Y P R O C E E D I N G S

1 PHILIPPE E. ZIMMERN, M.D.,
2 having been first duly sworn, testified as follows:
3 EXAMINATION
4 QUESTIONS BY MS. DONNA TAYLOR-KOLIS:
5 Q. Doctor, good evening.
6 A. Good evening.
7 Q. By way of introduction, my name is Donna
8 Kolis; and I have been retained to represent
9 Lynn and her husband, Kevin Keating in the
10 current action which is pending against
11 Dr. Makii. It's my understanding that you will
12 be serving as the expert witness for Dr. Makii,
13 and my purpose this evening is to find out what
14 opinions you hold -- since I have a letter
15 that's not too specific -- but be that as it
16 may, Doctor, for the record, state your name
17 and your professional address.
18 A. My name is Philippe, P-H-I-L-I-P-P-E,
19 Zimmern, Z-I-M-M-E-R-N. And I'm a professor of
20 urology UT Southwestern Medical Center in
21 Dallas.
22 Q. Doctor, have you ever served as a medical
23 expert before this occasion?
24 A. Yes, I have.
25

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 5

1 Q. All right. And on those occasions were
2 you required to give a deposition or testify at
3 trial?
4 A. Deposition.
5 Q. Okay. I'm just going to briefly review
6 deposition rules so that we have a foundational
7 place to start from. Obviously you're doing
8 extremely well; and you know that you have to
9 answer my questions verbally, correct?
10 A. Correct.
11 Q. This is a pretty good video conferencing
12 connection. I am not sensing a great delay in
13 terms of actual voice, but we should try to be
14 very careful to let each other finish
15 completely our thoughts in case there's a short
16 few seconds delay. All right?
17 A. All right.
18 Q. Okay. Can I safely assume, Doctor, since
19 it is now 8:00 p.m. in the evening, that you do
20 not have any professional responsibilities this
21 evening for which we would need to interrupt
22 the deposition?
23 A. I just turned my pager off. So the
24 answer is, yes, I do not.
25 Q. Okay. Fair enough.

Page 6

1 Doctor, what are you charging me
2 for your professional time to give this
3 deposition?
4 A. Great question, and I can't answer it
5 because I don't know the University fees. But
6 they can be provided to you, and maybe
7 Mrs. O'Brien knows because I really don't know.
8 It's not something that matters to me. It goes
9 to the University.
10 Q. Okay. Fair enough.
11 I'm certain that Ms. O'Brien
12 will make sure that I receive an appropriate
13 bill for this evening.
14 MS. O'BRIEN: I will.
15 Q. (BY MS. TAYLOR-KOLIS) Okay. Doctor, you
16 have authored one report and one report only,
17 I'm assuming; and it's dated March 27th, 2006;
18 is that correct?
19 A. It is correct.
20 Q. All right. When were you retained in
21 this matter?
22 A. I want to say a couple of weeks before
23 that, but maybe Mrs. O'Brien knows the exact
24 date. I have to admit I don't memorize these
25 things well, but couple of weeks probably would

Page 7

1 be reasonable.
2 Q. All right. Do you know Dr. Makii?
3 A. Do not.
4 Q. Do you know my expert, Dr. Lee Hamontree?
5 A. I have heard him speak once, but that's
6 pretty much it.
7 Q. All right. Do you have an opinion
8 relative to Dr. Hamontree's reputation as a
9 physician one way or another?
10 A. I do not have an opinion.
11 Q. Doctor, I see that sitting before you is
12 what is probably your file. Did you bring your
13 complete file?
14 A. I brought the -- all the documents that
15 were sent to me to review and I have two pages
16 of notes, factual notes of the date when things
17 took place and that's it.
18 Q. Okay. Could you inventory for
19 me -- that's a phrase we like to use -- what is
20 contained in the stack of documents that you
21 were provided?
22 A. Yes. On the left side here I have the
23 office records of Lynn Keating. That's from
24 Michael Makii, M.D. Then I have the outpatient
25 records, Volume 1 of 3, Volume 2 of 3, Volume 3

Page 8

1 of 3. And then I have the deposition of
2 Keating and Makii. One is dated December 2,
3 2005. The other one is dated November 4, 2005.
4 And as I said, I have my
5 two-page note, one page, two pages of basically
6 going over the chart. And I reviewed these
7 documents just from my own -- to allow me to
8 remember the facts in the order that things
9 happened.
10 Q. Okay. And do you have also with you your
11 correspondence file where you would have
12 received letters from either Ms. O'Brien or
13 Mr. Jones?
14 A. I do not.
15 Q. Okay. Fair enough.
16 Doctor, strange place to start
17 the deposition, I guess. Well, wait. I'm
18 going to think about this. The notes that you
19 have in front of you, the two pages of notes,
20 were those notes that you recently had written;
21 or were those the notes that you took as you
22 initially reviewed this case?
23 A. Those are the notes I initially took as I
24 reviewed the case.
25 Q. Will it be possible for you to have those

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 9

1 notes copied and give to the court reporter
2 this evening?
3 A. I have no problem. We can ask the
4 gentleman that set the room if he can do that,
5 but it will be fine. It's basically --
6 MS. O'BRIEN: If not, Donna,
7 we'll just give her the originals; and she can
8 copy them, addend them to the transcript; and
9 then he can get the originals back. But one
10 way or another we'll get them to you.
11 (Deposition Exhibit No. 1 marked.)
12 Q. (BY MS. TAYLOR-KOLIS) Okay.
13 Dr. Zimmern, have you, yourself, ever been a
14 defendant in a medical negligence case?
15 A. I have long ago when I was a UCLA
16 resident in training. I was named in a lawsuit
17 and which went to full trial. So it was not
18 directed to me directly, but I had -- as a
19 resident I was involved in that case at UCLA.
20 So it was not as far as anything recent, and
21 second, nothing since I've been here at the
22 University last ten years.
23 Q. All right. Relative to the lawsuit which
24 was filed while you were at UCLA, you indicate
25 that you were a resident. I know that was some

Page 10

1 time ago. Do you have a recollection of the
2 nature of the allegations of that lawsuit?
3 A. Yes. I remember the case which had to do
4 with an emergency surgery for a ruptured colon
5 during which a ureteric injury took place. And
6 my faculty was involved in fixing the ureteric
7 injury and putting a stent, which then
8 migrated. And that was one of the -- it was
9 not the main issue. It was just a side issue.
10 But everybody that took care of that patient
11 was named, basically.
12 Q. All right. Have you ever previously
13 worked for Ms. O'Brien, Mr. Jones, or any
14 member of their law firm?
15 A. I have not.
16 Q. Okay. Have you, Doctor, rendered
17 testimony in the state of Ohio by way of
18 deposition as an expert witness?
19 A. Not that I recall.
20 Q. Focusing ever so briefly on your
21 experience as an expert, with what frequency do
22 you review medical-legal matters?
23 A. Infrequently.
24 Q. Well, infrequent could be once every ten
25 years or once a year. Can you give me some

Page 11

1 idea of what that means?
2 A. Probably a couple of times a year. It
3 varies very much on my availability of being a
4 full-time faculty here, having residents to
5 train, fellows to train, travel abroad. It's
6 not a frequent thing for me to do.
7 Q. All right. And what kind of
8 people -- really bad question to ask you. You
9 don't know what kind of people they are. Are
10 you reviewing cases on behalf of defendant
11 doctors?
12 A. It can be either way, whomever contacts
13 me.
14 Q. Do you have a breakdown in your mind as
15 to what percentage of the deposition testimony
16 that you've given has been for the doctors
17 versus a patient?
18 A. No, I do not. I -- I frequently receive
19 requests for deposition which I cannot because
20 of the time line, you know, honor. And so I
21 would ask someone else to help out. Or if it's
22 just an advise through the University from my
23 lawyers, I may review, you know, a -- a
24 situation like that to give an expert opinion.
25 But, no, usually I don't do much of that.

Page 12

1 Q. When is the last time that you can recall
2 that you gave deposition testimony on behalf of
3 a patient?
4 A. I want to say a couple of years now.
5 Q. And what were the medical issues involved
6 in that case, to the best of your recollection?
7 A. It had to do with a woman who underwent a
8 prolapse repair, which is a pelvic hernia. And
9 she had some pain afterwards, and then she
10 was -- whether this was caused by the surgery
11 or was a pre-existing problem.
12 Q. And did you conclude in that matter it
13 was caused by the surgery?
14 A. I, frankly, don't recall at this point
15 what the conclusions were. I just remember,
16 you know, kind of the overall issue about the
17 case. But I can't remember the outcome, no.
18 Q. Okay. Doctor, you, of course, are board
19 certified in urology, correct?
20 A. Yes, ma'am.
21 Q. Okay. And you recently recer- -- well,
22 nine years ago you recertified. So you're
23 current in your board certifications, correct?
24 A. And I'm going to be up for
25 recertification again, yes.

Pages 9 to 12

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 13

1 Q. I would think so. Okay.
2 A. It's every ten years.
3 Q. Right. What percentage of your time do
4 you spend in the clinical practice of urology?
5 A. Probably -- it depends what you ask. If
6 you ask my wife, she will say 200 percent. If
7 you ask my chairman, he will probably say 80
8 percent because I have research and teaching
9 obligations. But I see patients on Monday and
10 Thursday every week. I operate on Tuesday,
11 Wednesday every week. And Friday is varied
12 between surgery and seeing patients.
13 Q. Okay. Doctor, I don't really have the
14 time or the inclination to go through your CV
15 in great detail; but I just want to ask you a
16 couple of questions about it.
17 A. Sure.
18 Q. If I'm reading this correctly, your
19 current academic post is director of the
20 Bladder and Incontinence Treatment Center.
21 A. This is correct.
22 Q. Am I reading --
23 A. Yes.
24 Q. Okay. And what is your primary focus at
25 your Bladder and Incontinence Treatment Center?

Page 14

1 A. Women who have incontinence problem,
2 prolapse problem, anything that has to do with
3 urological care of women, as well as voiding
4 dysfunction, as well as neurogenic bladders
5 which we see lot with patients who have
6 multiple sclerosis, spinal cord injury,
7 Parkinson's Disease. So it's probably 60
8 percent women's care and 40 percent men's care.
9 Q. Okay. I also noted, Doctor, from looking
10 at your CV that you are on the Editorial Board
11 of the Journal of Medicine and Pelvic Surgery;
12 is that right?
13 A. I was until a few months ago where they
14 rotated the -- the editorial board, which I
15 think is a brilliant idea and -- because I'm
16 busy enough and asked to be on other boards.
17 So it was perfectly fine with me.
18 Q. As a participant in the editorial board
19 for that journal, would you be one of the
20 people who peer reviewed submissions to be
21 published in the Journal?
22 A. Correct. I review submissions for that
23 journal as well as The Journal of Urology,
24 Urology, British Journal of Urology, European
25 Urology, NeuroUrology & Urodynamics, BJU, the

Page 15

1 British Journal of -- those are the most
2 frequent ones I'm asking to review. I do on
3 average five to ten articles review per month.
4 Q. Okay. To the best of your
5 recollection -- and I won't hold you to it, but
6 as closely as you can think of it, Doctor, in
7 the last five years in the Journal of Medicine
8 and Pelvic Surgery, were there any articles
9 published relative to the appropriate surgical
10 techniques and/or management of vesico-vaginal
11 fistula?
12 A. That's a great question. I just can't
13 answer that without checking back.
14 Q. Okay.
15 A. Do you have this information?
16 Q. Believe it or not, I don't. I was asking
17 you to see if you knew --
18 A. It's a topic that is of interest to all
19 of us, but there are not that many publications
20 on it.
21 Q. Okay.
22 A. I can tell you other journals I have
23 published on it, but that particular one I
24 don't know if they have the review or if they
25 have a case report. I'm certainly happy to

Page 16

1 look into that if that can help you.
2 Q. Okay. Going further into your curriculum
3 vitae, under miscellaneous on Page 9 I noted
4 with great interest that you have something
5 called the Vesico-vaginal and Ureterovaginal
6 Fistula Repairs. It's a UAU, [sic.] Compact
7 Disk Program produced in 1990, correct?
8 A. Correct.
9 Q. Where would one obtain such a compact
10 disk?
11 A. Probably have -- all this belongs to the
12 AUA Office of Education. So that would be
13 there. It's been, what, 16 years now.
14 Q. Yep.
15 A. I don't even have it anywhere in my
16 office I can think of.
17 Q. If I could -- if I could inquire, the AUA
18 has its Office of Education where?
19 A. I believe it's in Baltimore, Maryland. I
20 can provide you with the address.
21 Q. I can probably find it on the Internet.
22 I'm assuming -- I hope I'm not too tired to
23 assume wrongly, but AUA stands for the American
24 Urological Association?
25 A. Association, correct.

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 17

1 Q. Okay.

2 A. I just don't know how -- how far back

3 they keep those records because those are

4 courses. But it's their intellectual property

5 once we lecture this many.

6 Q. Well, it never hurts to ask. And so I'm

7 going to ask you this. And once again, I

8 realize that you might not have been prepared

9 to answer this particular question. But when

10 you produced this program -- and you say it was

11 a compact disk program -- was it a visual

12 learning tool, or was it written material or

13 both?

14 A. No, just written material.

15 Q. Okay. And you along with another author

16 put this material together, apparently a

17 Dr. Leach; is that right?

18 A. Dr. Gary Leach, yes.

19 Q. Okay. Would you be able to state one way

20 or another if the material that you wrote at

21 that time still constituted the standard of

22 care that should be employed in the repair of

23 vesico-virg- -- vaginal. Oh, we are

24 tired -- vaginal fistulas?

25 MS. O'BRIEN: Objection to the

Page 18

1 use of the term standard of care on a disk

2 but -- if you can answer.

3 A. Yeah. There is -- there has not been a

4 standard of care for this type of condition.

5 The purpose of that course is primarily to

6 educate urologists who are confronted with this

7 condition on how to deal with it, how to

8 evaluate it, and what are the principle of

9 management.

10 Q. (BY MS. TAYLOR-KOLIS) Okay.

11 A. It's really in truth not a demand where

12 we have guidelines or standard of care for

13 assessment that everybody agrees upon.

14 Q. I guess I'm going to ask a vague

15 question. Cheryl's going to say, "Good, I'll

16 object."

17 Are there principles of

18 management which should be adhered to?

19 A. I don't think so. The only way we could

20 get to that would be through randomized trials;

21 and this is such an infrequent condition that

22 this probably will never happen, frankly. Most

23 case report that you'll read in the literature

24 will be, you know 10, 15 20 cases here and

25 there over a number of years. So it's

Page 19

1 not -- it will take multiple centers when they

2 put their heads together to help you with

3 answering this question. As we speak today, we

4 do not have an agreed-upon standard of care for

5 everybody.

6 Q. When is the last time, Dr. Zimmern, that

7 you yourself performed a repair?

8 A. I do probably -- this last year we did

9 six. The year before I want to say seven. So

10 I would say every couple of months. I just did

11 a procedure a couple of weeks ago, and I just

12 saw a patient yesterday that will need that

13 repair done probably in June, July. So being a

14 specialized center, I get referrals of these

15 types of conditions.

16 Q. Okay. I'm going to ask you a question

17 however inartfully. A vesico-vaginal repair is

18 what kind of surgery, in your mind?

19 A. I'm not sure I completely understand your

20 question, but I hope I answer the way you -- to

21 answer really what you have in mind, it's

22 basically repairing a hole or a communication

23 that occurred between the bladder and the

24 vagina. This communication does not exist

25 naturally. It always happened after some form

Page 20

1 of event. And there are many etiologies.

2 There are many reasons, many causes for why

3 this can happen. Is this what you were asking?

4 Q. Well, that -- that was a good answer for

5 the way that I asked the question. So let me

6 ask a different question.

7 Is it fair to say that

8 gynecologists and urologists both are able to

9 do this repair?

10 A. Absolutely.

11 Q. Are there some instances relative to

12 fis- -- we'll just -- whenever I say fistula

13 repair, we'll assume for the sake of the

14 question that we're talking about the kind of

15 repair involved in this case but --

16 A. Fair enough.

17 Q. But -- right. A vesico-vaginal fistula,

18 we'll just deal with those in and of

19 themselves. Is there a situation where you

20 believe that a gynecologist should not perform

21 these repairs?

22 A. No, I don't think there is. This is a

23 judgment call on the part of the physician. It

24 will probably be based on experience. If the

25 fistula is not something that that person

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 21

1 repairs frequently, he or she may decide not to
2 do it. If that person received proper
3 training, I think, you know, if the patient has
4 properly consented and understand the issues
5 around the challenges of these repairs, I think
6 it can be repaired by anybody who feels
7 comfortable with this procedure.

8 Q. Okay. All right. I'm going to ask you
9 some questions, and hopefully I won't keep you
10 too terribly long. From your perspective as a
11 urologist who has been involved in repairs of
12 these kind of fistulas, what, Doctor, is the
13 principle of delayed repair?

14 A. What is the principle of delayed repair?
15 Yeah, that's a very good question. This
16 started, if I may go historically back, in the
17 1970s by a physician named Roger Barnes from
18 California. I had the privilege to train with
19 his grandson who is also a urologist, Dr. Roger
20 Headley. And back then women that had a
21 fistula, the feeling was that you had to wait a
22 number of months to allow the fistula to heal
23 before you would approach it surgically. He
24 bravely tried to operate on these women earlier
25 realizing that it was a very miserable life to

Page 22

1 lead continuously, and was the first one to
2 describe how you could do this operation
3 through the vagina and achieve a successful
4 result.

5 After that there was
6 still -- people divided on when it should be
7 done, and we've never completely all agreed
8 that when's the optimal time. As a specialist,
9 if someone comes tomorrow and just had a
10 fistula and wants to be repaired, I will go
11 ahead and do it. Many times I see people who
12 have had prior attempts at repairs. It's been
13 several months since the injury, and I will do
14 it as soon as they can be scheduled. So I
15 don't think we're very much bound by the timing
16 anymore. We try to help these people because
17 it is a very, you know, unpleasant condition to
18 have.

19 Q. Okay. Would you agree that now the
20 timing issue of a fistula repair is more
21 dictated by the nature of the local tissue
22 surrounding the fistula site than it is how far
23 out you are from the development of the
24 fistula?

25 A. No, I would not agree with that. It's

Page 23

1 one element in the decision process. If you do
2 have someone who's -- an infection or someone
3 who have had radiation or if you have any
4 reason why you would want to wait because you
5 think it's the proper thing to do, it's your
6 judgment call. If you think that, you know,
7 the -- you can see the hole. You can identify
8 it, and it can be repaired, there's no reason
9 to put someone through the miseries of
10 continuous leakage for another day if you think
11 you can fix it.

12 So the timing, the location, the
13 quality of the tissues, all those are part of
14 the elements that you as a physician have to
15 put together to -- with your patient to make a
16 decision. I have had a patient that have said
17 to me, "We should wait"; and some others have
18 said, "You know, I think the tissues are not
19 going to be any better probably." You have
20 chronic inflammation from the urine leaking
21 there, and let's fix it. So, no, there's no
22 rule of thumb for that.

23 Q. Okay. I'm going to get into the area
24 where I have to question you on your opinions,
25 and something just occurred to me. As you

Page 24

1 inventoried the material which you had, I did
2 not hear you disclose whether or not -- maybe
3 you don't it have. Have you received a copy of
4 Dr. Hamontree's deposition?

5 A. Of Dr. who? Yes, I did. I have it here.

6 MS. O'BRIEN: He's pointing to
7 the -- Donna, just to clar- -- he's pointing to
8 the report which I think he thought you said.
9 The deposition I just got this afternoon in my
10 office. So we haven't even had it copied yet.
11 He hasn't seen it.

12 THE WITNESS: Yeah. All I have
13 is a one-page note dated April 28, 2005.
14 That's all I have.

15 MS. TAYLOR-KOLIS: Okay. And
16 that fairly answers my question. I just wanted
17 to make sure that one way or the other whether
18 he had or had not read Dr. Hamontree's
19 deposition.

20 Q. (BY MS. TAYLOR-KOLIS) In your expert
21 report that I received sometime later in March,
22 you indicate -- and I'm just going to read it
23 to you just for setting the table, so to speak.
24 You said Dr. Makii met the standards for a
25 trained board certified gynecologist. I'm

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 25

1 assuming that you don't necessarily mean that
2 you know the standard of care for a board
3 certified gynecologist, but that he met the
4 standards of care for this surgery. Is that a
5 fair way to state that?
6 A. Well, I have a little bit of insight into
7 what the board certified gynecologist should
8 and should not do because I do work with them
9 all the time. We do have a -- a fellowship
10 which is run by the Board of Urology and the
11 Board of Gynecology. So I know a little bit
12 about what their curriculum should be and what
13 it shouldn't and that -- knowing that, no. So
14 that's why I wrote that.
15 Q. Okay. I just wanted to know why you
16 wrote it that way.
17 You then go on to say:
18 "Appropriate consenting was obtained in each
19 instance." We'll be discussing that.
20 Dr. Makii dealt with the complication in a
21 timely fashion. Even though it is an
22 unfortunate event after hysterectomy, Dr. Makii
23 ultimately managed to render this patient dry
24 again and continued to see her after her last
25 successful attempt. Then you indicate: This

Page 26

1 is only a brief summary of my findings which I
2 discussed in greater detail with you over the
3 phone. "These opinions stem from the
4 information I have reviewed thus far."
5 What I'm going to do is give you
6 an opportunity to share with me what you told
7 Ms. O'Brien were your more extensive opinions
8 in this case.
9 A. Well, I went --
10 Q. I gather that you --
11 A. Yes, I went through --
12 MS. O'BRIEN: Let me -- let me
13 just object in that our conversation was quite
14 awhile ago; and it was long before he made out
15 of country trips to France and everything,
16 Donna. So in all fairness, I think from his
17 notes he'll be able to give you a complete
18 rendition of his opinions; but I also want to
19 be sure that if you have any questions or any
20 specifics, please do ask because he may not,
21 you know, remember all the details. But
22 anyway, go -- we'll let him go first, and then
23 we'll see how we go from there.
24 MS. TAYLOR-KOLIS: That's fine.
25 A. I think what I was trying to communicate

Page 27

1 is that I couldn't see anything that was below
2 the standard of care anywhere along in my
3 review of these records. So we went step by
4 step through the procedures, the operative
5 notes, how the events unfolded all the way up
6 to the resolution of the problem, the
7 relationship between that physician and the
8 patient, how she, you know, was acquainted with
9 him, the fact that he just continued this care
10 all along and ultimately fixed this problem
11 which not always happens. I mean, many people
12 will come to me after three, four, five repairs
13 and still leak. So I think globally what I was
14 trying to say to Mrs. O'Brien at the time is
15 that I don't really understand very much the
16 reason for this -- you know, for all this.
17 Q. (BY MS. TAYLOR-KOLIS) Okay. All right.
18 We're going to do -- what I'm going to
19 do -- actually have written this out in
20 somewhat of an organized fashion. I want to go
21 through with you some of the things that
22 Dr. Makii said at his deposition. If you have
23 his deposition handy, that will probably work
24 for me.
25 A. Yes, I will pull that out here.

Page 28

1 Q. Okay. The first thing I want to discuss
2 with you today -- we'll go to Page 25 of his
3 deposition.
4 A. Yes.
5 Q. Okay. My question was to Dr. Makii, and
6 then there's a question for you after it. "As
7 you sit here today, Doctor, do you agree with
8 me that there isn't any documentation contained
9 within your chart that the presentation of this
10 complication with the fistula, that you advised
11 Lynn Keating and/or her husband, Kevin, that
12 there were people available within the
13 system" -- you see we're going -- we got to
14 skip down right there -- "that had more
15 expertise in fistula repairs?" And his answer
16 was: "I can't recall if I did."
17 Do you feel, Doctor, that when a
18 woman is confronted with a situation of
19 developing a fistula following a hysterectomy
20 that she should be given all options as to who
21 might do the surgery and what kind of
22 qualifications they have?
23 A. Well, I don't know how to answer that.
24 It's basically a discussion between him and the
25 patient. I never have the discussion with my

Pages 25 to 28

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 29

1 patients, frankly, because they have had that
2 discussion with other physicians before. And
3 so they come to me to fix the problem. So I'm
4 not very comfortable answering your question
5 because I don't know what really transpired
6 between them.

7 Q. Well, would you agree with me,
8 Doctor -- and certainly you can refer to
9 anything -- that the medical records that were
10 provided by Dr. Makii -- and, of course, he is
11 the author of both the in-hospital records and
12 the office chart -- do not reflect that
13 Dr. Makii, A, discussed anything with Lynn
14 other than immediately taking her for a
15 surgical repair?

16 A. I don't think we can infer that from the
17 records because it doesn't say that he didn't.
18 Obviously he knew her. She knew him. She had
19 assessed his qualifications, working in the
20 same environment. She chose him for the
21 repair. I'm sure he gave her some explanation.
22 It looks like he answered your questions, you
23 know, honestly. And I don't think -- you know,
24 if they recall what they said to each other,
25 that's one thing; but for us to say that they

Page 30

1 did not talk to each other and that this was
2 not communicated, I don't think I can read that
3 anywhere.

4 Q. All right. Well, let me rephrase and
5 make it simpler for you. First of all, is part
6 of the opinions that you hold in this case
7 predicated on the fact that you believe what
8 Dr. Makii testified to?

9 A. Well, here he testified that he can't
10 recall if I did exactly. So I just have to
11 take that.

12 Q. Well, have you taken into consideration
13 the testimony of Lynn Keating wherein she
14 indicates that options weren't discussed with
15 her?

16 A. That's what she says. It doesn't seem to
17 have the same opinion. I don't think I'm here
18 to, you know, debate that, am I?

19 Q. Well, no. But that's my point. If there
20 is a factual dispute between Dr. Makii and Lynn
21 Keating on some issues, I need to know if
22 you're resolving those facts in his favor to
23 reach your conclusion that he was within the
24 standards.

25 A. There is no standards about that that I

Page 31

1 know of. I can't give you a document that says
2 what should be told a patient or not prior to
3 procedure that I know of. I mean, maybe you
4 have the document. I've never read a document
5 like that. Obviously when you consent a
6 patient, you have to explain the surgery you're
7 going to do and the risk, and all I saw was a
8 consent that described what she had and the
9 repair was going to undertake. She signed it.
10 And beyond that, I think it's -- I mean, it's
11 just -- you know, I think we have to remain
12 neutral here. We don't know.

13 Q. Well, I don't want to be difficult; but I
14 guess my issue is this: If Dr. Makii's office
15 notes do not reflect and/or his hospital notes
16 do not reflect anything other than he explained
17 to the patient that she would need a surgical
18 repair, can we take that -- is that the
19 standard you need to document what it is you
20 discuss and tell a patient?

21 MS. O'BRIEN: I'll object in
22 that that's a different question but --

23 A. Yeah. I think it's basically his
24 practice. I don't know, you know, what he
25 does. I think there was clearly a trust

Page 32

1 relationship between them. I'm sure -- you
2 know, it shows all along. You just continue to
3 care for her all the way through until she
4 became dry. I'm sure he had no intention of,
5 you know, delegating that care to someone else
6 because she was trusting him to take care of
7 her. So I don't know that he even spent too
8 much time thinking that he had to write all
9 this down, and I'm sure he gave her the
10 information sufficient for her to proceed and
11 sign a consent. It was not done forcefully in
12 any way. She signed apparently and -- and
13 she's a nurse. She obviously knows more than
14 the average patient.

15 So I'm doubtful that they didn't
16 discuss anything, frankly. I can't imagine
17 that a nurse knowing a little bit about that
18 physician would have accepted to an operation
19 with no knowledge whatsoever of what he was
20 trying to do to help her. So, again, this is
21 inference. I don't think we know for sure that
22 nothing happened or that nothing was said.
23 That would surprise me a great deal.

24 Q. (BY MS. TAYLOR-KOLIS) Doctor, are you
25 implying to me that there are no standards of

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 33

1 care that require doctors to document their
2 interactions with patients completely?
3 A. Not that I know of. I think the level of
4 documentation varies tremendously. I'm just
5 back from a trip in Europe. I can tell you you
6 wouldn't find much in the chart in Europe.
7 Here it varies a lot. In my many years of
8 reviewing those entries some people are very
9 detailed. Some say nothing.
10 Q. Doctor, do you participate in your
11 hospital's JCHA evaluations?
12 A. We do. I don't do directly, but our
13 university does.
14 Q. Do you suspect that JCHA has something to
15 say about medical documentation?
16 A. Oh, they do; but I don't know what the
17 standards are, you know, for Dr. Makii in the
18 state he's in. I know what our standards are
19 here at the University where we have an
20 electronic record for everything we do. You
21 probably know that more than I do. I really
22 don't know that part.
23 Q. Moving on to my next line of questions.
24 Page 38 in Dr. Makii's deposition. On Page 38
25 somewhere line -- about Lines 10 to 14 I asked

Page 34

1 him about the size. And this is questions that
2 I'm asking out of his operative note. I said:
3 "I think it was described as it says they were
4 unable to see the entire bladder because as I
5 stated earlier it was a small, I'd say,
6 four- to five-millimeter hole." And he says:
7 "Right."
8 I take it for purposes of my
9 question you're going to accept that this was a
10 four- to five-millimeter hole, right?
11 A. Well, if I remember correctly -- and I
12 can recheck that -- he was able to put a
13 catheter through it. So I think that would be
14 a correct assessment.
15 Q. Okay. Doctor, can a four- to
16 five-millimeter hole heal without surgical
17 intervention?
18 A. The answer, maybe; but in reality I don't
19 recall an instance where that would close by
20 itself. The holes that have been in the
21 literature stated as closing are usually
22 smaller, like three millimeter or smaller.
23 Again, here we're on a vague area because no
24 one really has a caliper to measure that size
25 exactly. So the way I judge that was the fact

Page 35

1 that he was able to put a small catheter
2 through it, which makes sense knowing the
3 diameter of the catheter and what he reported.
4 And I think he has experience from when I read
5 about him before about repairing fistulas. So
6 it looks like it's a reasonable assessment and
7 judgment on his part.
8 Q. Okay. I just want to establish that
9 you're saying that a four- to five-millimeter
10 hole wouldn't heal on its own?
11 A. Very unlikely.
12 Q. Okay. Our medical standard is more
13 likely than not, meaning more than 51 percent.
14 In your experience and based upon your review
15 of the literature, a four- to five-millimeter
16 hole wouldn't have healed on its own?
17 A. It would not, especially if you have a
18 catheter, and the catheter does not provide
19 dryness. So he tried to put the catheter, if I
20 recall, properly and even increase the size of
21 the catheter; and she continued to leak. So
22 it's unlikely that it's going to -- you can
23 send someone home leaking with a large catheter
24 saying, you know, "Let's pray and hope it's
25 going to close by itself." I don't think that

Page 36

1 makes much sense.
2 Q. Okay. All right. Moving on to my next
3 question. On Page 46 of Dr. Makii's
4 deposition, the question above where we're
5 going to start because I wanted him to
6 describe the surgical procedure he used in that
7 first attempted repair. Have you read his
8 description in his deposition of what he did,
9 Lines 10 to 20?
10 A. No, I have not in detail read that
11 because I read his operative note. So I did
12 not pick up anything I was really concerned
13 about. Okay. So I have read Lines 17 to 20.
14 Okay.
15 Q. Okay. What -- what surgical procedure is
16 he describing to you? And if you don't know
17 what I mean by that, what technique is he
18 describing?
19 A. He's describing basically a primary
20 closure of a fistula. So he closes the bladder
21 mucosa, the tissue in between, and then the
22 vaginal mucosa. And he says --
23 Q. What tissue in between, I'm sorry?
24 A. Well, the tissue in between, you describe
25 that as interstitial tissue. And usually it's,

Pages 33 to 36

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 37

1 you know, the -- some bladder wall or some, you
2 know, serosa material between the bladder and
3 the vagina. So he tried to put, you know,
4 additional layer of closure between the bladder
5 and the vaginal closure.
6 Q. And based upon the description in his
7 operative report and then his answer on that
8 page, you feel he was using appropriate
9 surgical techniques to ensure a repair of this
10 fistula?
11 A. I'll go back to the operative records to
12 verify that, but I would say yes to your
13 question. Let me just reread the operative
14 note to be totally accurate.
15 Q. Okay.
16 A. This is -- what's the date on this one?
17 The first one was 9/25/03, correct?
18 Q. I --
19 MS. O'BRIEN: 9/30.
20 Q. (BY MS. TAYLOR-KOLIS) I believe she was
21 historically --
22 A. 9/30, 9/30/03. Okay.
23 Q. Right. There you go.
24 A. To describe a four- to five-millimeter
25 hole. So you put a pressuring suture like he

Page 38

1 describes, and then with another layer of
2 pressuring over that. So you had two layers
3 over the fistula, and the patient was dry. And
4 so he felt that, you know, he had accomplished
5 a watertight repair; and he was comfortable
6 with the -- with the step. And he left the
7 catheter to drain the bladder, and that was it.
8 So I think that's fine.
9 Q. Okay. Doctor, is -- is it standard or
10 standard of care -- and I know you are saying
11 that you don't think there's standards, but
12 we'll see -- at the time of a fistula repair,
13 should the ureters be evaluated?
14 A. If you see the fistula where he described
15 it and it's away from the ureters, that's all
16 you can say. It doesn't say that it's close to
17 the ureters anywhere.
18 Q. So you feel that it was not necessary for
19 him to evaluate the ureters at the time of the
20 first repair?
21 A. Well, I'm sure he looked at it. I mean,
22 he's -- from what I've read from his histories,
23 he's a board certified physician. He's trained
24 as a gynecologist/oncologist. So he knows
25 about ureters and pelvic cancers. So I have

Page 39

1 all reasons to believe that he checked that
2 out. And if the person became dry after the
3 hole is closed, why would you think that there
4 is anything going on with another organ.
5 Q. Mrs. Keating stayed dry about six days,
6 didn't she?
7 A. The next operation was on October 9. So
8 I would say that's probably correct, yeah.
9 Q. Do you remember that she contacted
10 Dr. Makii on October 6th, and she was leaking
11 urine?
12 A. The exact date, no, I don't recall; but I
13 know it happened, you know, in the following,
14 you know, days after this repair.
15 Q. Okay. What do you make of Dr. Makii's
16 testimony that the hole in the bladder is a new
17 hole in the bladder?
18 A. Where would that be?
19 Q. You can look on Page 51, Lines 8
20 through 15.
21 A. Well, I think I -- I don't remember
22 reading that in the deposition. I think I
23 remember reading that in his operative note,
24 which would be October 9. Let me reverify
25 that.

Page 40

1 Q. Okay.
2 A. Where is this -- October 9th he looks for
3 a hole. I think he was looking where the prior
4 hole was and he couldn't find it and then he
5 saw a jet of water coming from another
6 location. So I think that's -- so it looks
7 like, one, the place he had repaired had held;
8 and another place maybe opened up that was not
9 visible before. That could be an explanation.
10 Q. Do you have an opinion to a reasonable
11 degree of medical probability as to why, first
12 of all, this second area -- I don't know if you
13 want to call it failed or was no longer intact?
14 A. I have seen this scenario before, and I
15 think it has to do with the healing of what we
16 call the cuff, the top of the vagina where the
17 hysterectomy took place. All you can do when
18 you repair a fistula is repair what you see,
19 and you could -- you know, there obviously was
20 nothing else leaking at the time. Otherwise he
21 would have seen it. So I think he goes back
22 and realizes that there is now another opening
23 that was not obviously present last time he was
24 there. So it -- you know, he probably assumed
25 that what he had closed had reopened like you

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 41

1 and I would have suspected, but apparently he
2 meets another area where this occurred as well.
3 Q. In Dr. Makii's office notes -- and you
4 can look at the notes. You'll look at the
5 deposition. But at Page 52 I'm discussing with
6 him what he wrote in his note. And he
7 says -- I'm going to quote him. He says: "It
8 says the concept for repairing this is pretty
9 straightforward, but this is a relatively
10 difficult time secondary to the problems she
11 had earlier with steroids."

12 Do you -- do you agree that this
13 is a difficult secondary problem because of her
14 steroids?

15 A. That's an interest question. I don't
16 know the answer, frankly. I looked at the dose
17 of steroids she was on, and there is a -- the
18 only thing I could find was a note from the
19 cardiologist who cleared her for the surgery on
20 9/25 mentioning that she was taking steroids
21 for her arthritic joint, that this crisis
22 apparently had resolved and that the dose was
23 being tapered. So you're looking now at a
24 pretty low dose of Prednisone, five milligram.
25 We operate on people who are -- you know, on

Page 42

1 immunosuppressant, a much higher dose, without
2 being too worried about it.

3 So maybe for him it meant he was
4 more concerned or maybe for him that explained
5 why she didn't heal as well as someone else
6 would have healed. I think it's very hard to
7 tell that for -- for -- is this the only
8 reason, I don't know that. She's not on a high
9 dose of steroids. You know, I think she's
10 really at a -- she probably just had a boost of
11 steroids just because of the arthritis issue.

12 And it's, you know, about to be out of her
13 system. So I didn't make much of that, to be
14 honest with you.

15 Q. All right. So you wouldn't have been
16 concerned about the steroids in this instance;
17 is that correct?

18 A. That's right, I would not have been.

19 Q. All right. And do you believe that the
20 dosage of steroids that she was on as
21 calculated by yourself in looking carefully
22 through the notes would have affected her
23 ability to heal?

24 A. Well, that's what's difficult to tell
25 because I don't think we know that how long the

Page 43

1 steroid effect could prevent this area from
2 healing. That's why I can't say that this is
3 not contributing to this problem. But to say
4 that's the only reason why it happened, most of
5 the time the fistula I've dealt with, people
6 were doing their procedure and never even have
7 a clue that anything was going on. And it
8 happens. So it happens with people that do not
9 take steroids. So to say that this is why, may
10 be a little bit farfetched to be really fair.
11 To say did not contribute, no, I don't think
12 you can say that because, yes, steroids do
13 affect your healing properties. So that's a
14 fair comment. I would not have -- I mean, if a
15 patient come like that to me tomorrow, I would
16 go ahead with the repair. You know, I don't
17 think that would have stopped me from repairing
18 her at the time.

19 Q. Okay. On that same page, Page 52, I was
20 having a conversation with Dr. Makii back in
21 November. What -- we began to talk about how
22 long it had been since that initial fistula
23 repair, and it's Line 20 through 25. He says,
24 "Yeah, it's several weeks from the initial
25 surgery that we did her hysterectomy, and then

Page 44

1 it's a week out of -- roughly a week out of the
2 repair of the fistula that we had done. And so
3 at this point in time, you know, the tissues
4 are going to be more edematous and more
5 friable."

6 Would you agree with him that
7 that's the way the tissues would have been at
8 that time?

9 A. Probably -- probably true, but this is a
10 young person. She's otherwise healthy. She's
11 ~~50 years old. You know, tissues heal pretty~~
12 quickly. I think it's -- you know, he was
13 there. I wasn't. So, you know, it looks like
14 it's his judgment call that maybe, you know,
15 this could contribute to the whole process.
16 I'm not sure I know what to -- I mean, it's not
17 surprising that what the -- you know, all
18 tissues after surgery have some edema and are
19 friable. So I think it's correct, but I can't
20 quantitate that for you or say, you know, this
21 has anything to do with what happened
22 afterwards.

23 Q. Okay. Going further in Dr. Makii's
24 deposition testimony on Page 54 starting at
25 Line 13 I ask him, and once again more relative

Pages 41 to 44

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 45

1 to the second situation: "Why did you
2 suspect -- well, what was the cause of the
3 leaking in your opinion at that time?" And he
4 say: "Well, first I didn't see that it was in
5 the area that we had repaired, and it was along
6 the mid portion of the vaginal cuff. So I was
7 thinking that we had an erosion of the sutures
8 through the posterior bladder wall."

9 Doctor, do you think that that's
10 what happened, there was an erosion in the
11 sutures through the bladder wall?

12 A. I mean, that makes some sense given what
13 he described in his report.

14 Q. Now, how does that happen that the
15 sutures erode through the bladder wall? What
16 would be the cause of that?

17 A. Well, some people will say that, you
18 know, when you tie them if they're tied too
19 tight, you can cut the blood circulation. Some
20 people have suggested that maybe your body's
21 reactive to the sutures. So you increase an
22 area of inflammation. I think all of these are
23 different, very conjectural thoughts, you know.
24 I think he's trying to understand what may have
25 happened, but I don't know if we'll ever know.

Page 46

1 It just happened. Most of the time we don't
2 know. There's a hole, and we have to fix it.
3 That's the bottom line.

4 Q. Okay. This particular second repair,
5 Doctor, I don't know if you remember it; but it
6 will be easy to remember because the doctor
7 testified to it. This particular procedure
8 took three hours. When I asked him about it,
9 if you look on Page 56, his answer to me when I
10 asked him why it took so long to do this
11 procedure, he said: "We had a lot of bleeding
12 and as I previously said previously, the tissue
13 was rather necrotic. So we had to cut it back
14 until we got good, good tissue."

15 Do you see that?

16 A. I see that, yes.

17 Q. That's his testimony that at that time
18 when they went in to do this particular repair
19 that the tissue was very necrotic.

20 A. I see that.

21 Q. Okay. Again, Doctor, at the time of this
22 particular procedure preoperatively,
23 interoperatively should there have been a
24 complete evaluation of the ureters?

25 A. I don't think so. Again, the way you

Page 47

1 describe is he does a cystoscopy; and he finds,
2 you know, a new hole. So he sees the hole, and
3 the hole goes clearly from the bladder to the
4 vagina. So I'm not sure that there's any
5 reason to question what's going on with the
6 ureters.

7 Q. Okay. What would lead you to believe
8 something was going on with the ureters? What
9 sort of symptoms would you see?

10 A. Well, if you close the hole between the
11 bladder and the vagina and the person still
12 leaks, obviously there's a hole somewhere else.
13 If the person has fever, flank pain because
14 they -- the tube has been kinked or is not
15 draining properly, those are the types of
16 things that usually, you know, raise suspicion.
17 Or if you look at the time of your scope and
18 you don't see any jet of urine coming out, you
19 may, you know, wonder. But that's -- usually
20 you're worried when the hole is close to the
21 ureters, which is not a frequent issue when the
22 injury occurs at the time of the hysterectomy
23 just because the cuff is usually fairly far
24 from the ureters and what we call the trigone,
25 which is the area between the two ureters. So

Page 48

1 usually those fistulas of the cuff are far away
2 from the ureters. So it's very unlikely that
3 the ureters had anything to do with this, and
4 it's probably why he didn't even care for it.

5 Q. She ultimately had a problem with her
6 ureters. Would you agree with that -- ureter?

7 A. There was some swelling around the
8 ureteric orifice which prevented the kidney
9 from draining well on the right side. But we
10 can't say there was really a problem. They
11 were able to pass a stent easily, and
12 ultimately this area healed. So I think if
13 there was a problem, then things would not have
14 healed. And it's common when you open the
15 bladder that you get to have some tissue
16 swelling, and the tissue swelling can involve,
17 you know, the ureter. They are in close
18 proximity. So, no, that doesn't surprise me
19 much. It's a common problem.

20 Q. Okay. Doctor, do you have an opinion to
21 a reasonable degree of medical probability as
22 to whether or not the second repair which
23 occurred on October 9th should have been a flap
24 procedure?

25 A. Can you explain what you mean by a "flap

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 49

1 procedure?"
2 Q. The procedure that was ultimately
3 performed the third time.
4 MS. O'BRIEN: I'm not sure I
5 understand that question. I think I can -- are
6 you asking him whether or not he thinks the
7 procedure that was ultimately done on 11/7
8 should have been on 10/9 and because it
9 wasn't --
10 MS. TAYLOR-KOLIS: Correct.
11 MS. O'BRIEN: -- was it beneath
12 the standard of care? That's what she's
13 asking.
14 MS. TAYLOR-KOLIS: That's
15 absolutely correct.
16 A. So the question is should he have opted
17 for abdominal surgery at the time as opposed to
18 going back vaginally?
19 Q. (BY MS. TAYLOR-KOLIS) Correct.
20 A. Again, here you have to go with his
21 judgment and expertise and experience. It's
22 preferable to continue to work vaginally,
23 especially in this particular patient, if I
24 recall well, she has had two prior scars from
25 C-section and appendectomy. They had

Page 50

1 difficulty with her rectus muscle on the right
2 side. So I would be very tempted not to go in
3 the abdomen again. So I have no problem with
4 his judgment call to go back through the
5 vagina. And here again, from reading his
6 notes, he seemed to have achieved a
7 satisfactory repair. Everything is dried, and
8 he was able to put several layers on top. So I
9 think he exercised really good judgment. I
10 mean, this is not someone I would want to
11 reoperate through the abdomen.
12 Q. Okay. If you look at the office notes,
13 on October 24th Dr. Makii pulled out the Foley.
14 But at that time he did not get a cysto. Do
15 you think that that is below the standard of
16 care?
17 A. I'm lost here. Is it still in the
18 deposition? I don't know where we are.
19 MS. O'BRIEN: No. I think
20 you're just asking him straight out of the
21 office record, aren't you Donna?
22 MS. TAYLOR-KOLIS: Yeah.
23 Q. (BY MS. TAYLOR-KOLIS) Yeah, it's in his
24 deposition, but to make it easier on Page 62,
25 lines 15 through 20, I discussed with

Page 51

1 him -- right. I said -- the question I asked
2 him was -- the line of questions. This is when
3 he pulls out her cysto on the 27th -- her
4 cysto. It's too late in the evening to be
5 doing this deposition. Her Foley. "Is it
6 because usually before I pull, before I pull a
7 catheter, I usually get -- I want to see
8 because I usually get a cystogram. No, I
9 didn't get one." Customarily I said: "Why do
10 you get one?"
11 He said: "To make sure that she
12 does not have any further leakage and that the
13 repair is intact."
14 So my question to you is:
15 Should she have had a cysto on the 27th?
16 A. A cysto meaning a cystogram?
17 Q. Yes.
18 A. I don't think we have an agreement on
19 that. Some people do. Some people don't.
20 There are arguments against a cystogram, and
21 those are the risk of, you know, bringing
22 infection in the bladder or distending the
23 bladder too much and, therefore, maybe
24 stretching the repair and reopening the
25 fistula. So, you know, I think if the person

Page 52

1 is dry, the cystogram does not add anything.
2 If the person leaks, you really want to know
3 where the leakage comes from maybe.
4 But, you know, I think again
5 here it looks to me like what transpires
6 through his report all along that it is a
7 fairly good level of comfort with what he did
8 achieving dryness. And he has said in his
9 deposition that he has been trained to do
10 fistula repairs. He has done them in his
11 training. I think he feels competent to take
12 care of her. And he documents each time that
13 he has accomplished the goal of making her dry.
14 So I don't think he's doubting
15 his results, frankly. So why would you ask for
16 an extra test with the reddition involvement,
17 the risk of infection, stretching the bladder
18 for what, you know. So I have no problem with
19 him not getting one. I probably would not have
20 gotten one either myself at that stage.
21 Q. Doctor, do you recall that by November
22 3rd Mrs. Keating was, once again, leaking; and
23 she describes it as spraying uncontrollably,
24 correct?
25 A. Yeah. I don't remember how she describes

Pages 49 to 52

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 53

1 it; but she apparently -- something happened at
2 some point. She went to San Diego or she went
3 to see her parents or something happened
4 and -- this is a bit vague in my recollection
5 of what happened during that one month or so.
6 But the bottom line is what she said. She
7 started to leak again.

8 Q. Right. Well, there wasn't a month -- I
9 mean, from the 27th when he starts on November
10 3rd, that's not very many days, is it?

11 A. Well, the second repair was October 9,
12 correct; and his next repair was 11/7. So it's
13 almost a month. So I just don't know the exact
14 timing of when it recurred. I don't know
15 exactly when she left to San Diego to see her
16 parents either. But I suspect she went there
17 and was doing fine. Otherwise, she would not
18 have probably decided to go that far away from
19 him. So I have to suspect she was dry for a
20 while, correct?

21 Q. Could you know -- in the interim between
22 the time of that repair and then the time of
23 the visit where he pulled the Foley, could you
24 say she was dry during then?

25 A. I don't know if I can say that. I don't

Page 54

1 know if I cannot say that. I don't remember
2 specifically -- I mean, I would assume that if
3 you remove the Foley is because she's dry.
4 Otherwise, why would you remove the Foley. But
5 then after that how long it took for the leak
6 to reoccur -- no, I would tell my patients not
7 to travel as far away as she did if she had
8 that type of repair, frankly. So I was
9 surprised to see her go, you know, away just
10 after, you know, this repair. Again, they may
11 have talked about that together; and he may
12 have told her that it was fine. I don't know
13 that.

14 Q. But you wouldn't have told a patient to
15 take a trip that extensive, would you?

16 A. No, I wouldn't.

17 Q. Okay. And there's no documentation that
18 Dr. Makii put those kind of restrictions on
19 her, is there?

20 A. Well, as you pointed out before, there
21 may be many things that he has said and not
22 documented because, you know, I don't know if I
23 even document that in my -- I don't tell my
24 patient, "Don't go to San Diego," after my
25 repair; but I will tell them, you know, "I will

Page 55

1 like you to have, you know, a more quiet
2 lifestyle. Make sure there's no pulling or
3 tugging on your body, that you're not going to
4 travel too far or too much." And it's kind of
5 a common sense, you know.

6 I don't know if he knew she was
7 going to travel. Again, they work in the same
8 hospital. He described her initially in his
9 report as being a friend of mine. So did she
10 call him and say, "You know, by the way, I'm
11 going to San Diego. Is this fine with you?" I
12 don't know that, you know.

13 Q. Dr. Makii described Lynn Keating as being
14 a friend of his at his deposition, correct?

15 A. Yes. That's what I read. He said,
16 "She's a friend of mine."

17 Q. Right. But he didn't say that in his
18 medical notes or his hospital chart, correct?

19 A. That, I don't recall. I remember reading
20 it in his deposition. I was interested to know
21 what type of relationship they had.

22 Q. Okay.

23 A. Maybe it's somewhere else. I don't know
24 if it's somewhere else.

25 Q. If you can find it someplace else, I

Page 56

1 cannot. It's what he testified to at his
2 deposition.

3 A. Okay.

4 Q. Okay. Direct your attention to Page 66
5 of Dr. Makii's deposition.

6 A. Yes.

7 Q. He and I had been having a discussion on
8 the previous page about why the sutures were
9 disrupted, et cetera, after the 27th but up to
10 the time of the 3rd. And what I want you to
11 focus on -- and I'm going to read this to you,
12 and we're going to talk about what he says in
13 his deposition.

14 "I think as I explain, or maybe
15 I didn't, but in these repairs usually if you
16 do these repairs, usually we wait for a while
17 for the underlying inflammation to die down and
18 then go back to when there's more of an
19 established scar tissue and less inflammatory
20 response. And then -- then we do the repairs.
21 These were all discussed with Lynn and she did
22 not want to wait three months and that's part
23 of the reason why."

24 Do you get the clear import from
25 that note?

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 57

1 A. And then he adds: "And being a friend of
2 mine, I felt I could try to help her as much as
3 we could."

4 Correct, that's the end of
5 the -- of the paragraph.

6 Q. Yes, and thank you for reading that; but
7 my question doesn't have to do with his
8 assertion that she's his friend. Do you read
9 that to mean that Dr. Makii believes, contrary
10 to what you said, that you really should wait
11 for a period of time before you do this repair?

12 MS. O'BRIEN: Objection in that
13 you said that's contrary to what Dr. Zimmern
14 said. I didn't hear any testimony to that
15 effect, Donna; but if you want to ask your
16 question.

17 Q. (BY MS. TAYLOR-KOLIS) Dr. Zimmern, I
18 believe that you testified way early in the
19 deposition, because that's where my questions
20 were, about timing no -- I discussed with you
21 the principle of delayed repair, and you said
22 that was no longer a principle that people can
23 and do --

24 A. Some people hold this as an absolute
25 principle. Some others are more lenient about

Page 58

1 it. I have learned, you know, over the last 25
2 years that you can be more lenient. And so you
3 can go ahead early, and you can go ahead late.
4 Usually people go ahead as soon as they can to
5 fix it in their own judgment. So, yeah, I
6 agree with Ms. O'Brien. I don't think, you
7 know, there is again a party line of when you
8 should absolutely go in. For a long time the
9 prevalent idea that you had to wait; but as I
10 explained, this has evolved towards people
11 would go in early or whenever the patients
12 present, so...

13 Q. If you go to Page 67, lines about 21
14 through 25, I believe, so that it's
15 clear -- and I want to make sure that you
16 understand it -- do you understand Dr. Makii's
17 testimony to be that under the circumstances of
18 Lynn Keating that he would have preferred not
19 to do a surgery because he believes that her
20 best chance for fixing this problem would have
21 been to rest that area?

22 A. Yeah. I think that's what he does
23 indicate.

24 Q. Okay. And he claims that it is Lynn that
25 did not want to wait, and so he went ahead and

Page 59

1 did the surgery; is that right?

2 A. Well, that was my impression as well.

3 Q. And, once again -- and I'm not going to
4 be beat a dead horse -- can you agree with me
5 that those kinds of pieces of advice, any of
6 those conversations are not contained anywhere
7 within the four corners of the medical records?

8 A. I would agree with you, I did not see
9 that in writing anywhere either.

10 Q. Okay. All right. What I'd like to do
11 now is you may -- obviously you do know that
12 Ms. O'Brien had the opportunity to already take
13 the deposition of Dr. Hamontree. That's how we
14 do things. My guy goes first, and then we take
15 you. So what I want to do is I'm going to read
16 to you out of Dr. Hamontree's deposition some
17 of his opinions, and I'd like for you to
18 comment on them. Okay?

19 A. Okay.

20 MS. O'BRIEN: Donna, let me just
21 put an objection on the record in that he has
22 not seen it. He hasn't had the chance to read
23 it in context, and it's putting him at a
24 tremendous disadvantage. But it's your
25 deposition. So go ahead.

Page 60

1 MS. TAYLOR-KOLIS: Right. And
2 I'm not trying to put him at a disadvantage. I
3 think the context will be clear because they
4 were straightforward questions by yourself as
5 to what the deviations were. So I don't think
6 there's a whole lot of possibility to be
7 confused but -- because I just want to go
8 through them just to see how Dr. Zimmern might
9 reason through what Dr. Hamontree thinks.

10 Q. (BY MS. TAYLOR-KOLIS) Essentially we're
11 going to Page 23, and I'm sorry Cheryl does not
12 have one. But if I'm wrong, the verbatim will
13 work out.

14 Initially they're looking at the
15 situation that occurred on 9/30, and the first
16 thing that Dr. Hamontree has concern with is as
17 follows, Page 23 Lines 14 through 25: "My
18 criticism -- or let me just summarize the
19 problems. We want to go through the op report
20 because you lead me there. But the problems
21 that I see is this: There were no upper tract
22 evaluations performed such as an IVP or a
23 retrograde ureterogram."

24 Do you disagree with
25 Dr. Hamontree that that's a problem?

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 61

1 A. I don't view that as a problem for this
2 particular situation. I think if the fistula
3 was close to the ureters, if the patient had
4 not been made dry after the repair, yes. But
5 the assessment of the upper tracts, again, is
6 something that some people do; some people
7 don't. In my particular practice, because I
8 deal with patients who have had several repairs
9 before, I tend to be -- agree more with
10 Dr. Hamontree, and maybe that's where he's
11 coming from. We really want to check
12 everything out before we go through the 5th or
13 6th or 7th repair. But, again, here in the
14 context, I would not support this as being, you
15 know, a firm, you know, below the standard of
16 care type of thing, not at all.

17 Q. Okay. Skipping down the same page -- I'm
18 just going to go to the next page, Page 23 of
19 Line 23: "He essentially did a purse string of
20 the bladder and a purse string of the vaginal
21 epithelium, one right on top of each other.
22 There was no -- so there was overlapping suture
23 line, no intervening healthy tissue."

24 Do you agree with his assessment
25 that that's what occurred at this surgery, that

Page 63

1 you know, like when you repair a hole in your
2 shirt or anything else. So you do the first
3 area, it's closed. It's dry. And then you got
4 to have another purse string, obviously taking
5 tissue further out away from where the hole was
6 initially. So I don't see how that can overlap
7 at all. Maybe it's my understanding of what he
8 describes, but I don't see it as a problem at
9 all.

10 Q. Okay. What do you make of his contention
11 that there was no intervening healthy tissue?

12 A. Well, there cannot be any, otherwise you
13 would have a hole, correct. I mean, you
14 have -- a fistula goes directly from the
15 bladder to the vagina. So you don't have
16 anything in between. What we usually do, we
17 try to bring tissues from lateral to the hole
18 to try to have the layer or, you know, some
19 form of interposition. And usually the
20 adjacent bladder tissue is healthy enough that
21 you can do that. And that's, again, what I
22 think he's trying to do with this second purse
23 string.

24 Q. Okay. Once again, we probably already
25 covered this; but I'm just going to

Page 62

1 first of all what we've got is a purse string
2 of the bladder and a purse string of the
3 vaginal epithelium, one on top of each other?

4 A. You're referring to the 9/30/03
5 procedure?

6 Q. Correct.

7 A. Yeah, the problem with the purse
8 string -- and we all know what a purse string
9 looks like. I don't know if you can say that
10 it overlaps because when we do several purse
11 strings, most of them don't overlap. You're
12 going to have one purse string right around
13 this four-, five-millimeter hole; and then
14 you're going to have, from what you describe, a
15 wider purse string to kind of imbricate it
16 over. So I can't physically imagine how they
17 can overlap. They're going to be in different
18 planes, one reinforcing the other, but not on
19 top of each other, obviously. I mean, you
20 can't put a second purse string where the first
21 one was. So I'm not sure I understand this
22 issue that -- or what he's trying to say here.

23 Maybe it's my understanding of
24 the words purse string. When we do a purse
25 string, we basically throw a suture gradually,

Page 64

1 do -- Ms. O'Brien did a nice job of logically
2 following through to find out what his
3 criticisms were. And on Page 25, line of
4 questioning 15 through 25, Cheryl is
5 saying -- and I asked you one way, and you
6 answered another. But I think we're in
7 agreement as to what you're saying. This leads
8 me to my next question. If, in fact, your
9 conclusion is accurate that what he achieved
10 was overlapping or adjacent suture lines, do
11 you feel that fell below the standard of care
12 and was negligent? His answer, Doctor, is: "I
13 think it is, particularly doing a repair
14 immediately after surgery rather than waiting
15 or trying conservative treatment."

16 "Will you know whether or not he
17 authored the treatment or if that was discussed
18 with the patient?"

19 "I don't know, but I think if
20 you were going to undertake an immediate
21 surgical repair in tissue that has just been
22 operated on, then you really, really have to
23 adhere to the guiding principles of a fistula
24 repair; or you are going to have to have a high
25 chance of failure of a recurrent fistula."

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 65

1 Having read his question and
2 answer -- I'm not asking if you agree with his
3 answer -- Doctor, do you believe that there are
4 principles of fistula repair in terms of
5 surgical technique?
6 A. There are principles that have been, you
7 know, published. If everybody who does fistula
8 repair have their own principles, it's like,
9 you know, the cook in the kitchen is doing a
10 recipe his way and someone else does a
11 different way. Do we all agree on the
12 principles? We don't. I train in two
13 countries, and I can tell you the way I repair
14 fistula now has nothing to do with the way I
15 was taught to repair fistula. And as I said
16 earlier, unfortunately we don't see that
17 problem frequently enough that we will probably
18 ever sort that out.
19 So I'm sure that Dr. Hamontree
20 refers to principles he has in mind, which
21 probably ten other people in the field would
22 probably disagree with to some degree. Here
23 he's arguing that he should not have done this
24 repair, you know, at the time when it is clear
25 that he has tried to control the leakage with

Page 66

1 increasing size catheters. You know, he knows
2 that if -- it's going to be a hard thing to
3 live with to have this continuous leakage; and
4 he's trying to help her by fixing the problem
5 early on, which in my experience is a way to go
6 if you recognize there's a problem, why leave
7 someone miserable when you have a small hole
8 that is potentially fixable.
9 Q. Okay. So you got sort of away from my
10 question, but that's all right. Doctor, you've
11 indicated to me on the record that you are
12 training residents and fellows. And I assume
13 that's residents and fellows in urology,
14 correct?
15 A. That is correct.
16 Q. All right. Are you the person
17 responsible, either in a didactic setting or
18 clinical setting, to teach your urology -- I'm
19 going to call them students, but they're far
20 more than students -- how to do a
21 vesico-vaginal fistula repair?
22 A. Correct. That's my own recipe, yeah.
23 Q. Could you tell me what Philippe Zimmern's
24 recipe is for this kind of fistula repair?
25 A. Do you have another three or four hours?

Page 67

1 I can -- I mean, I can --
2 Q. I --
3 A. It's a great question, but it will depend
4 on where it is, how large. I mean, there's so
5 many factors. There's not just one way,
6 unfortunately. So, you know, you're trying
7 to -- you can't reduce it to fixed like, you
8 know, dogma, like if you have pneumonia and you
9 need some antibiotics to fix the pneumonia,
10 this doesn't happen for this type of problems.
11 I have never seen two equal fistulas. I have
12 never seen two people with the same problem,
13 the same tissues, the same set of
14 circumstances. So I agree that the principles
15 are good in general, but we're never shown that
16 if you depart from some of those principles it
17 means that the repair will fail.
18 Here you have someone with
19 training, who feels comfortable dealing with
20 it, tries a conservative approach that clearly
21 doesn't work, wants to help the patient achieve
22 dryness during the procedure. You know, that's
23 her life. If all operations we did were
24 successes, that would be wonderful. And these
25 things happen where people fail. I mean, I see

Page 68

1 that all the time. So I wish we had
2 principles. And when I discuss that with our
3 residents and fellows, I explain that the way I
4 do it is the way I've evolved into doing it;
5 but I have failures like everybody else. It's
6 hard to admit that we can fail, but we do fail.
7 Q. Doctor, do you believe that there is such
8 a thing as medical malpractice?
9 A. Yes, I think I do because we have -- we
10 have to take tests every year about that. So
11 we do have, and we have a law in Texas about
12 that.
13 Q. What kind of law is that?
14 A. You're asking me too much. I'm not a
15 lawyer; but, you know, we have malpractice law
16 where our university asks us to take courses
17 about that, you know. So I don't know if there
18 is a name or a year specific to it. That's not
19 my field of knowledge, but we know we have
20 malpractice laws in Texas.
21 Q. Okay. I guess I was confused about what
22 you just testified to. I was interpreting it
23 to mean that the University required that you,
24 Dr. Zimmern, take a course to understand the
25 laws of medical malpractice in Texas.

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 69

1 A. Yes.
2 Q. Did I misinterpret?
3 A. No, no. This is correct. We have to
4 answer a certain number of questions every year
5 or every two years. I can't remember how often
6 that is. It's not a course. I think it's a
7 multiple choice question that we have.
8 Q. And out of curiosity, did you pass or
9 fail that test?
10 A. No. I've always passed. All our faculty
11 pass.
12 Q. I thought that was a great question,
13 personally.
14 MS. O'BRIEN: A little out on a
15 limb, it's fairly irrelevant, but go ahead.
16 MS. TAYLOR-KOLIS: Yeah. You
17 know, I guess what I'm going to --
18 MS. O'BRIEN: It's the hour.
19 MS. TAYLOR-KOLIS: It probably
20 is partially that.
21 Q. (BY MS. TAYLOR-KOLIS) And this won't get
22 me any great trial testimony, but are you one
23 of the physicians who's been out advocating
24 medical malpractice tort reform over the last
25 year, eight years?

Page 70

1 MS. O'BRIEN: Objection;
2 irrelevant.
3 Have you even had the time to do
4 that?
5 THE WITNESS: I wish I had the
6 time to do that.
7 Q. (BY MS. TAYLOR-KOLIS) Okay. So you're
8 in favor of medical malpractice tort reform?
9 MS. O'BRIEN: Objection. Move
10 to strike. But for your own personal
11 edification, you're certainly welcome to his
12 opinion.
13 A. Yes.
14 Q. (BY MS. TAYLOR-KOLIS) Okay. Let me see.
15 If I take what you have said to me, even though
16 your -- and how many residents and fellows do
17 you have in your program, Doctor?
18 A. Great question. We have 16 four-year,
19 over four years. And I have been involved with
20 a fellowship program now for seven years with
21 Dr. Leach and ten years here at the University.
22 So 17 years.
23 Q. Okay. Having said that, I gather, then,
24 that you have taught the principles of
25 vesico-vaginal fistula repair for some time and

Page 71

1 to a large number of people?
2 A. No, that's not correct. I don't teach
3 principles.
4 Q. Okay.
5 A. I explain to people how I try to repair
6 fistula and the type of issues I've encountered
7 in my practice. But I have yet to agree with
8 principle that Dr. Leach or someone else in the
9 field would agree with me. We don't have
10 those, I'm sorry to say. There are concept,
11 there are ideas, but principle is a very strong
12 word. It means that if you don't do that
13 you're doing something wrong, and we don't know
14 that.
15 Q. Okay. Can I infer from that, then,
16 that -- and I could be inferring the complete
17 wrong thing, that anytime that there is a
18 failed fistula repair it possibly could not be
19 from medical negligence; it's just from a
20 judgment call?
21 A. Neither one. It just -- could be just
22 that the repair did not hold, period. We don't
23 even understand why this fistula formed to
24 start with most of the time. So healing is not
25 something that we control. I wish we could.

Page 72

1 Q. Okay. Doctor --
2 A. I don't think you realize the complexity
3 of fistula repair. This is not an easy topic
4 because we don't have much knowledge. We don't
5 have much scientific knowledge about it. There
6 are many different ways of doing things
7 depending on your background and your training.
8 All I see here is someone with apparently
9 credentials to do this repair who failed
10 initially but ultimately made it through in a
11 short time all together. Because I see some of
12 these problems evolving sometimes over two or
13 three years. And I don't see anything below
14 the standard of care here.
15 Q. Doctor, when was the first -- since you
16 seem to be obviously a very interested
17 academic, can you tell me from your knowledge
18 of the medical literature when the first
19 fistula repair was described?
20 A. It was -- it was back, you know, in the
21 slave times where people were using, in fact,
22 metal to close that. And the first patients
23 that were treated were, in fact, black slaves.
24 You're going back to the end of the last
25 century. And there are different names, but I

ORAL DEPOSITION OF PHILIPPE E. ZIMMERN, M.D.

Page 77

I, PHILIPPE ZIMMERN, M.D., have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

PHILIPPE ZIMMERN, M.D.
Job #57036

THE STATE OF _____)
THE COUNTY OF _____)

Before me, _____, on this day personally appeared PHILIPPE ZIMMERN, M.D., known to me (or proved to me under oath or through _____) (description of identity card or other document)) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office, this _____ day of _____, _____.

NOTARY PUBLIC IN AND FOR
THE STATE OF _____
COMMISSION EXPIRES: _____

Page 78

1 STATE OF TEXAS)
2 COUNTY OF DALLAS)

3 REPORTER'S CERTIFICATE
4 I, DAWN M. GREEN, Certified Shorthand
5 Reporter in and for the State of Texas, hereby
6 certify that this transcript is a true record of the
7 testimony given.

8 I further certify that I am neither
9 attorney nor counsel for, related to, nor employed
10 by any of the parties to the action in which this
11 testimony was taken. Further, I am not a relative
12 or employee of any attorney of record in this cause,
13 nor do I have a financial interest in the action.

14 Subscribed and sworn to on this the 17th day of
15 April, 2006.
16

17 Dawn M. Green, CSR
18 Certified Shorthand Reporter
19 In and for the State of Texas
20 Certification No. 5178
21 Expiration Date: 12/31/2007
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coming (3) 40:5 47:18
61:11
comment (2) 43:14
59:18
COMMISSION (1)
77:24
common (4) 1:1
48:14,19 55:5
communicate (1)
26:25
communicated (1)
30:2
communication (2)
19:22,24
compact (3) 16:6,9
17:11
competent (1) 52:11
complete (5) 7:13
26:17 46:24 71:16
73:4
completely (4) 5:15
19:19 22:7 33:2
complexity (1) 72:2
complication (2)
25:20 28:10
concept (2) 41:8
71:10
concepts (2) 73:10,11
concern (1) 60:16
concerned (3) 36:12
42:4,16
conclude (1) 12:12
conclusion (2) 30:23
64:9
conclusions (1)
12:15
condition (4) 18:4,7
18:21 22:17
conditions (1) 19:15
CONFERENCE (2)
1:9 3:1
conferencing (1) 5:11
confronted (2) 18:6
28:18
confused (2) 60:7
68:21
conjectural (1) 45:23
connection (1) 5:12
consent (3) 31:5,8
32:11
consented (1) 21:4
consenting (1) 25:18
conservative (2)
64:15 67:20
consideration (2)
30:12 77:18
constituted (1) 17:21
contacted (1) 39:9
contacts (1) 11:12
contained (3) 7:20
28:8 59:6
contention (1) 63:10
context (3) 59:23 60:3
61:14
continue (2) 32:2

49:22
continued (3) 25:24
27:9 35:21
continuous (2) 23:10
66:3
continuously (1) 22:1
contrary (2) 57:9,13
contribute (2) 43:11
44:15
contributing (1) 43:3
control (2) 65:25
71:25
conversation (2)
26:13 43:20
conversations (1)
59:6
cook (1) 65:9
copied (2) 9:1 24:10
copy (2) 9:8 24:3
cord (1) 14:6
corners (1) 59:7
correct (35) 5:9,10
6:18,19 12:19,23
13:21 14:22 16:7,8
16:25 34:14 37:17
39:8 42:17 44:19
49:10,15,19 52:24
53:12,20 55:14,18
57:4 62:6 63:13
66:14,15,22 69:3
71:2 73:19,22 77:3
corrections (3) 74:15
74:20,22
correctly (2) 13:18
34:11
correspondence (1)
8:11
counsel (1) 78:9
countries (1) 65:13
country (1) 26:15
COUNTY (3) 1:2 77:9
78:2
couple (8) 6:22,25
11:2 12:4 13:16
19:10,11 73:25
course (5) 12:18 18:5
29:10 68:24 69:6
courses (2) 17:4
68:16
court (2) 1:1 9:1
covered (1) 63:25
credentials (1) 72:9
crisis (1) 41:21
criticism (1) 60:18
criticisms (1) 64:3
CSR (2) 3:6 78:17
cuff (4) 40:16 45:6
47:23 48:1
curiosity (1) 69:8
current (3) 4:11 12:23
13:19
curriculum (2) 16:2
25:12
Customarily (1) 51:9
cut (2) 45:19 46:13

CUYAHOGA (1) 1:2
CV (2) 13:14 14:10
cysto (5) 50:14 51:3,4
51:15,16
cystogram (4) 51:8
51:16,20 52:1
cystoscopy (1) 47:1
C-section (1) 49:25

D

D (1) 2:1
Dallas (3) 3:9 4:22
78:2
date (6) 6:24 7:16
37:16 39:12 76:2
78:19
dated (4) 6:17 8:2,3
24:13
Dawn (4) 1:14 3:5
78:4,17
day (4) 23:10 77:12
77:20 78:14
days (5) 39:5,14
53:10 74:13,17
dead (1) 59:4
deal (4) 18:7 20:18
32:23 61:8
dealing (1) 67:19
dealt (2) 25:20 43:5
debate (1) 30:18
December (1) 8:2
decide (1) 21:1
decided (1) 53:18
decision (2) 23:1,16
defendant (3) 3:19
9:14 11:10
degree (3) 40:11
48:21 65:22
delay (2) 5:12,16
delayed (3) 21:13,14
57:21
delegating (1) 32:5
demand (1) 18:11
depart (1) 67:16
Department (1) 3:8
depend (1) 67:3
depending (1) 72:7
depends (1) 13:5
deposition (42) 1:9
3:1 5:2,4,6,22 6:3
8:1,17 9:11 10:18
11:15,19 12:2 24:4
24:9,19 27:22,23
28:3 33:24 36:4,8
39:22 41:5 44:24
50:18,24 51:5 52:9
55:14,20 56:2,5,13
57:19 59:13,16,25
73:16 76:2 77:2
describe (6) 22:2 36:6
36:24 37:24 47:1
62:14
described (8) 31:8
34:3 38:14 45:13
55:8,13 72:19 73:24

describes (4) 38:1
52:23,25 63:8
describing (3) 36:16
36:18,19
description (4) 2:11
36:8 37:6 77:14
detail (3) 13:15 26:2
36:10
detailed (1) 33:9
details (1) 26:21
developing (1) 28:19
development (1)
22:23
deviations (1) 60:5
diameter (1) 35:3
dictated (1) 22:21
didactic (1) 66:17
die (1) 56:17
Diego (4) 53:2,15
54:24 55:11
different (8) 20:6
31:22 45:23 62:17
65:11 72:6,25 73:12
difficult (4) 31:13
41:10,13 42:24
difficulty (1) 50:1
Direct (1) 56:4
directed (1) 9:18
directly (3) 9:18 33:12
63:14
director (1) 13:19
disadvantage (2)
59:24 60:2
disagree (2) 60:24
65:22
disclose (1) 24:2
discuss (4) 28:1
31:20 32:16 68:2
discussed (7) 26:2
29:13 30:14 50:25
56:21 57:20 64:17
discussing (2) 25:19
41:5
discussion (4) 28:24
28:25 29:2 56:7
Disease (1) 14:7
disk (4) 16:7,10 17:11
18:1
dispute (1) 30:20
disrupted (1) 56:9
distending (1) 51:22
divided (1) 22:6
DIVISION (1) 1:1
doctor (36) 4:6,17,23
5:18 6:1,15 7:11
8:16 10:16 12:18
13:13 14:9 15:6
21:12 28:7,17 29:8
32:24 33:10 34:15
38:9 45:9 46:5,6,21
48:20 52:21 64:12
65:3 66:10 68:7
70:17 72:1,15 73:22
74:5
doctors (4) 11:11,16

33:1 73:4
document (7) 31:1,4
31:4,19 33:1 54:23
77:15
documentation (4)
28:8 33:4,15 54:17
documented (1)
54:22
documents (4) 7:14
7:20 8:7 52:12
dogma (1) 67:8
doing (9) 5:7 43:6
51:5 53:17 64:13
65:9 68:4 71:13
72:6
DOMIANO (1) 3:15
Donna (10) 2:6 3:15
4:5,8 9:6 24:7 26:16
50:21 57:15 59:20
dosage (1) 42:20
dose (5) 41:16,22,24
42:1,9
doubtful (1) 32:15
doubting (1) 52:14
Dr (50) 4:12,13 7:2,4
7:8 9:13 17:17,18
19:6 21:19 24:4,5
24:18,24 25:20,22
27:22 28:5 29:10,13
30:8,20 31:14 33:17
33:24 36:3 39:10,15
41:3 43:20 44:23
50:13 54:18 55:13
56:5 57:9,13,17
58:16 59:13,16 60:8
60:9,16,25 61:10
65:19 68:24 70:21
71:8
drain (1) 38:7
draining (2) 47:15
48:9
dried (1) 50:7
dry (12) 25:23 32:4
38:3 39:2,5 52:1,13
53:19,24 54:3 61:4
63:3
dryness (3) 35:19
52:8 67:22
duly (2) 3:3 4:3
dysfunction (1) 14:4

E

E (6) 1:10 2:1 3:1,13
3:13 4:2
earlier (5) 21:24 34:5
41:11 65:16 73:24
early (4) 57:18 58:3
58:11 66:5
easier (1) 50:24
easily (1) 48:11
East (1) 3:21
easy (2) 46:6 72:3
edema (1) 44:18
edematous (1) 44:4
edification (1) 70:11

editorial (3) 14:10,14
14:18
educate (1) 18:6
Education (2) 16:12
16:18
effect (2) 43:1 57:15
eight (1) 69:25
either (6) 8:12 11:12
52:20 53:16 59:9
66:17
electronic (1) 33:20
element (1) 23:1
elements (1) 23:14
emergency (1) 10:4
employed (2) 17:22
78:9
employee (1) 78:12
encountered (1) 71:6
ensure (1) 37:9
entire (1) 34:4
entries (1) 33:8
environment (1)
29:20
epithelium (2) 61:21
62:3
equal (1) 67:11
erode (1) 45:15
erosion (2) 45:7,10
especially (2) 35:17
49:23
essentially (2) 60:10
61:19
establish (1) 35:8
established (1) 56:19
et (2) 1:4 56:9
etiologies (1) 20:1
Europe (2) 33:5,6
European (1) 14:24
evaluate (2) 18:8
38:19
evaluated (1) 38:13
evaluation (1) 46:24
evaluations (2) 33:11
60:22
evening (10) 4:6,7,14
5:19,21 6:13 9:2
51:4 73:15 74:2
event (2) 20:1 25:22
events (1) 27:5
everybody (5) 10:10
18:13 19:5 65:7
68:5
evolved (2) 58:10
68:4
evolving (1) 72:12
exact (3) 6:23 39:12
53:13
exactly (3) 30:10
34:25 53:15
examination (3) 2:6
4:4 73:9
examinations (2)
73:3,3
executed (1) 77:17
exercised (1) 50:9

Exhibit (2) 2:10 9:11
exist (1) 19:24
experience (6) 10:21
20:24 35:4,14 49:21
66:5
expert (7) 4:13,24 7:4
10:18,21 11:24
24:20
expertise (2) 28:15
49:21
Expiration (1) 78:19
EXPIRES (1) 77:24
explain (5) 31:6 48:25
56:14 68:3 71:5
explained (3) 31:16
42:4 58:10
explanation (2) 29:21
40:9
expressed (1) 77:18
extensive (2) 26:7
54:15
extra (1) 52:16
extremely (1) 5:8

F

fact (6) 27:9 30:7
34:25 64:8 72:21,23
factors (1) 67:5
facts (2) 8:8 30:22
factual (2) 7:16 30:20
faculty (3) 10:6 11:4
69:10
fail (5) 67:17,25 68:6
68:6 69:9
failed (3) 40:13 71:18
72:9
failure (1) 64:25
failures (1) 68:5
fair (8) 5:25 6:10 8:15
20:7,16 25:5 43:10
43:14
fairly (4) 24:16 47:23
52:7 69:15
fairness (1) 26:16
far (10) 9:20 17:2
22:22 26:4 47:23
48:1 53:18 54:7
55:4 66:19
farfetched (1) 43:10
fashion (2) 25:21
27:20
favor (2) 30:22 70:8
Fax (2) 3:18,24
feel (4) 28:17 37:8
38:18 64:11
feeling (1) 21:21
feels (3) 21:6 52:11
67:19
fees (1) 6:5
fell (1) 64:11
fellows (5) 11:5 66:12
66:13 68:3 70:16
fellowship (2) 25:9
70:20
felt (2) 38:4 57:2

fever (1) 47:13
field (3) 65:21 68:19
71:9
file (3) 7:12,13 8:11
filed (1) 9:24
financial (1) 78:13
find (7) 4:14 16:21
33:6 40:4 41:18
55:25 64:2
findings (1) 26:1
finds (1) 47:1
fine (7) 9:5 14:17
26:24 38:8 53:17
54:12 55:11
finish (1) 5:14
firm (2) 10:14 61:15
first (18) 4:3 22:1
26:22 28:1 30:5
36:7 37:17 38:20
40:11 45:4 59:14
60:15 62:1,20 63:2
72:15,18,22
fis (1) 20:12
fistula (42) 15:11 16:6
20:12,17,25 21:21
21:22 22:10,20,22
22:24 28:10,15,19
36:20 37:10 38:3,12
38:14 40:18 43:5,22
44:2 51:25 52:10
61:2 63:14 64:23,25
65:4,7,14,15 66:21
66:24 70:25 71:6,18
71:23 72:3,19 73:10
fistulas (5) 17:24
21:12 35:5 48:1
67:11
five (4) 15:3,7 27:12
41:24
five-millimeter (7)
34:6,10,16 35:9,15
37:24 62:13
fix (6) 23:11,21 29:3
46:2 58:5 67:9
fixable (1) 66:8
fixed (2) 27:10 67:7
fixing (3) 10:6 58:20
66:4
flank (1) 47:13
flap (2) 48:23,25
Floor (1) 3:22
Floor-Standard (1)
3:16
flying (1) 74:8
focus (2) 13:24 56:11
Focusing (1) 10:20
Foley (5) 50:13 51:5
53:23 54:3,4
follow (1) 74:14
following (3) 28:19
39:13 64:2
follows (2) 4:3 60:17
forcefully (1) 32:11
foregoing (2) 77:2,16
form (2) 19:25 63:19

formed (1) 71:23
forth (1) 74:15
Forward (1) 74:6
foundational (1) 5:6
four (11) 27:12 34:6
34:10,15 35:9,15
37:24 59:7 62:13
66:25 70:19
four-year (1) 70:18
France (1) 26:15
frankly (7) 12:14
18:22 29:1 32:16
41:16 52:15 54:8
frequency (1) 10:21
frequent (3) 11:6 15:2
47:21
frequently (3) 11:18
21:1 65:17
friable (2) 44:5,19
Friday (2) 13:11 74:18
FRIEDMAN (1) 3:15
friend (5) 55:9,14,16
57:1,8
front (1) 8:19
full (1) 9:17
full-time (1) 11:4
further (6) 16:2 44:23
51:12 63:5 78:8,11

G

Gary (1) 17:18
gather (2) 26:10
70:23
general (1) 67:15
gentleman (1) 9:4
getting (1) 52:19
give (10) 5:2 6:2 9:1,7
10:25 11:24 26:5,17
31:1 74:17
given (5) 11:16 28:20
45:12 77:19 78:7
globally (1) 27:13
go (32) 13:14 21:16
22:10 25:17 26:22
26:22,23 27:20 28:2
37:11,23 43:16
49:20 50:2,4 53:18
54:9,24 56:18 58:3
58:3,4,8,11,13
59:25 60:7,19 61:12
61:18 66:5 69:15
goal (1) 52:13
goes (5) 6:8 40:21
47:3 59:14 63:14
going (50) 5:5 8:6,18
12:24 16:2 17:7
18:14,15 19:16 21:8
23:19,23 24:22 26:5
27:18,18 28:13 31:7
31:9 34:9 35:22,25
36:5 39:4 41:7 43:7
44:4,23 47:5,8
49:18 55:3,7,11
56:11,12 59:3,15
60:11 61:18 62:12

62:14,17 63:25
64:20,24 66:2,19
69:17 72:24
good (11) 4:6,7 5:11
18:15 20:4 21:15
46:14,14 50:9 52:7
67:15
gotten (1) 52:20
gradually (1) 62:25
grandson (1) 21:19
great (10) 5:12 6:4
13:15 15:12 16:4
32:23 67:3 69:12,22
70:18
greater (1) 26:2
Green (4) 1:14 3:5
78:4,17
guess (5) 8:17 18:14
31:14 68:21 69:17
guidelines (1) 18:12
guiding (1) 64:23
guy (1) 59:14
gynecologist (4)
20:20 24:25 25:3,7
gynecologists (1)
20:8
gynecologist/oncol...
38:24
Gynecology (1) 25:11

H

Hamontree (7) 7:4
59:13 60:9,16,25
61:10 65:19
Hamontree's (4) 7:8
24:4,18 59:16
hand (1) 77:19
Handwritten (1) 2:12
handy (1) 27:23
happen (5) 18:22 20:3
45:14 67:10,25
happened (12) 8:9
19:25 32:22 39:13
43:4 44:21 45:10,25
46:1 53:1,3,5
happens (3) 27:11
43:8,8
happy (1) 15:25
hard (5) 42:6 66:2
68:6 73:23 74:1
Harry (1) 3:9
Headley (1) 21:20
heads (1) 19:2
heal (6) 21:22 34:16
35:10 42:5,23 44:11
48:12,14
healed (4) 35:16 42:6
48:12,14
healing (4) 40:15 43:2
43:13 71:24
healthy (4) 44:10
61:23 63:11,20
hear (2) 24:2 57:14
heard (1) 7:5
held (1) 40:7
help (8) 11:21 16:1

19:2 22:16 32:20
 57:2 66:4 67:21
hereto (1) 3:11
hernia (1) 12:8
he'll (1) 26:17
high (2) 42:8 64:24
higher (1) 42:1
Hines (1) 3:9
historically (2) 21:16
 37:21
histories (1) 38:22
hold (5) 4:15 15:5
 30:6 57:24 71:22
hole (26) 19:22 23:7
 34:6,10,16 35:10,16
 37:25 39:3,16,17
 40:3,4 46:2 47:2,2,3
 47:10,12,20 62:13
 63:1,5,13,17 66:7
holes (1) 34:20
home (1) 35:23
honest (1) 42:14
honestly (1) 29:23
honor (1) 11:20
hope (3) 16:22 19:20
 35:24
hopefully (1) 21:9
horse (1) 59:4
hospital (3) 31:15
 55:8,18
hospital's (1) 33:11
hour (1) 69:18
hours (2) 46:8 66:25
hurts (1) 17:6
husband (2) 4:10
 28:11
hysterectomy (5)
 25:22 28:19 40:17
 43:25 47:22

I

idea (3) 11:1 14:15
 58:9
ideas (1) 71:11
identify (1) 23:7
identity (1) 77:14
imagine (2) 32:16
 62:16
imbricate (1) 62:15
immediate (1) 64:20
immediately (2) 29:14
 64:14
immunosuppressa...
 42:1
implying (1) 32:25
import (1) 56:24
impression (1) 59:2
inartfully (1) 19:17
inclination (1) 13:14
includes (1) 73:9
incontinence (3)
 13:20,25 14:1
increase (2) 35:20
 45:21
increasing (1) 66:1

INDEX (1) 2:10
indicate (4) 9:24
 24:22 25:25 58:23
indicated (1) 66:11
indicates (1) 30:14
infection (3) 23:2
 51:22 52:17
infer (2) 29:16 71:15
inference (1) 32:21
inferring (1) 71:16
inflammation (3)
 23:20 45:22 56:17
inflammatory (1)
 56:19
information (3) 15:15
 26:4 32:10
infrequent (2) 10:24
 18:21
Infrequently (1) 10:23
inhospital (1) 29:11
initial (2) 43:22,24
initially (6) 8:22,23
 55:8 60:14 63:6
 72:10
injury (5) 10:5,7 14:6
 22:13 47:22
inquire (1) 16:17
insight (1) 25:6
instance (4) 3:2 25:19
 34:19 42:16
instances (1) 20:11
instrument (1) 77:16
intact (2) 40:13 51:13
intellectual (1) 17:4
intention (1) 32:4
interactions (1) 33:2
interest (4) 15:18
 16:4 41:15 78:13
interested (2) 55:20
 72:16
interim (1) 53:21
Internet (1) 16:21
interoperatively (1)
 46:23
interposition (1)
 63:19
interpreting (1) 68:22
interrupt (1) 5:21
interstitial (1) 36:25
intervening (2) 61:23
 63:11
intervention (1) 34:17
introduction (1) 4:8
inventoried (1) 24:1
inventory (1) 7:18
involve (1) 48:16
involved (6) 9:19 10:6
 12:5 20:15 21:11
 70:19
involvement (1) 52:16
irrelevant (2) 69:15
 70:2
issue (8) 10:9,9 12:16
 22:20 31:14 42:11
 47:21 62:22

issues (4) 12:5 21:4
 30:21 71:6
IVP (1) 60:22

J

JCHA (2) 33:11,14
jet (2) 40:5 47:18
job (3) 1:14 64:1 77:7
joint (1) 41:21
Jones (2) 8:13 10:13
journal (8) 14:11,19
 14:21,23,23,24 15:1
 15:7
journals (1) 15:22
judge (1) 34:25
judgment (9) 20:23
 23:6 35:7 44:14
 49:21 50:4,9 58:5
 71:20
July (1) 19:13
June (1) 19:13

K

Keating (11) 1:4 4:10
 7:23 8:2 28:11
 30:13,21 39:5 52:22
 55:13 58:18
keep (2) 17:3 21:9
Kevin (2) 4:10 28:11
kidney (1) 48:8
kind (12) 11:7,9 12:16
 19:18 20:14 21:12
 28:21 54:18 55:4
 62:15 66:24 68:13
kinds (1) 59:5
kinked (1) 47:14
kitchen (1) 65:9
knew (4) 15:17 29:18
 29:18 55:6
know (134) 5:8 6:5,7
 7:2,4 9:25 11:9,20
 11:23 12:16 15:24
 17:2 18:24 21:3
 22:17 23:6,18 25:2
 25:11,15 26:21 27:8
 27:16 28:23 29:5,23
 29:23 30:18,21 31:1
 31:3,11,12,24,24
 32:2,5,7,21 33:3,16
 33:17,18,21,22
 35:24 36:16 37:1,2
 37:3 38:4,10 39:13
 39:13,14 40:12,19
 40:24 41:16,25 42:8
 42:9,12,25 43:16
 44:3,11,12,13,14,16
 44:17,20 45:18,23
 45:25,25 46:2,5
 47:2,16,19 48:17
 50:18 51:21,25 52:2
 52:4,18 53:13,14,21
 53:25 54:1,9,10,12
 54:22,22,25 55:1,5
 55:6,10,12,12,20,23
 58:1,7 59:11 61:15

61:15 62:8,9 63:1
 63:18 64:16,19 65:7
 65:9,24 66:1 67:6,8
 67:22 68:15,17,17
 68:19 69:17 71:13
 72:20 73:13
knowing (3) 25:13
 32:17 35:2
knowledge (5) 32:19
 68:19 72:4,5,17
known (1) 77:13
knows (5) 6:7,23
 32:13 38:24 66:1
Kolis (1) 4:9

L

large (3) 35:23 67:4
 71:1
late (2) 51:4 58:3
lateral (1) 63:17
law (4) 10:14 68:11,13
 68:15
laws (2) 68:20,25
lawsuit (3) 9:16,23
 10:2
lawyer (1) 68:15
lawyers (1) 11:23
layer (3) 37:4 38:1
 63:18
layers (2) 38:2 50:8
Leach (4) 17:17,18
 70:21 71:8
lead (3) 22:1 47:7
 60:20
leads (1) 64:7
leak (4) 27:13 35:21
 53:7 54:5
leakage (5) 23:10
 51:12 52:3 65:25
 66:3
leaking (6) 23:20
 35:23 39:10 40:20
 45:3 52:22
leaks (2) 47:12 52:2
learned (1) 58:1
learning (1) 17:12
leave (3) 66:6 73:23
 74:1
lecture (1) 17:5
Lee (1) 7:4
left (3) 7:22 38:6
 53:15
lenient (2) 57:25 58:2
letter (1) 4:15
letters (1) 8:12
let's (2) 23:21 35:24
level (2) 33:3 52:7
life (2) 21:25 67:23
lifestyle (1) 55:2
limb (1) 69:15
line (12) 11:20 33:23
 33:25 43:23 44:25
 46:3 51:2 53:6 58:7
 61:19,23 64:3
lines (8) 33:25 36:9

36:13 39:19 50:25
 58:13 60:17 64:10
literature (4) 18:23
 34:21 35:15 72:18
little (5) 25:6,11 32:17
 43:10 69:14
live (1) 66:3
local (1) 22:21
location (2) 23:12
 40:6
logically (1) 64:1
long (8) 9:15 21:10
 26:14 42:25 43:22
 46:10 54:5 58:8
longer (2) 40:13
 57:22
look (7) 16:1 39:19
 41:4,4 46:9 47:17
 50:12
looked (2) 38:21
 41:16
looking (5) 14:9 40:3
 41:23 42:21 60:14
looks (7) 29:22 35:6
 40:2,6 44:13 52:5
 62:9
lost (1) 50:17
lot (4) 14:5 33:7 46:11
 60:6
low (1) 41:24
Lynn (11) 1:4 4:10
 7:23 28:11 29:13
 30:13,20 55:13
 56:21 58:18,24
L.P.A (1) 3:15

M

M (4) 1:14 3:5 78:4,17
machine (1) 3:7
main (1) 10:9
Makii (22) 1:6 4:12,13
 7:2,24 8:2 24:24
 25:20,22 27:22 28:5
 29:10,13 30:8,20
 33:17 39:10 43:20
 50:13 54:18 55:13
 57:9
Makii's (8) 31:14
 33:24 36:3 39:15
 41:3 44:23 56:5
 58:16
making (1) 52:13
malpractice (6) 68:8
 68:15,20,25 69:24
 70:8
managed (1) 25:23
management (3)
 15:10 18:9,18
March (2) 6:17 24:21
marked (2) 2:11 9:11
Maryland (1) 16:19
material (6) 17:12,14
 17:16,20 24:1 37:2
matter (2) 6:21 12:12
matters (3) 6:8 10:22

73:1
 ma'am (1) 12:20
 mean (21) 25:1 27:11
 31:3,10 36:17 38:21
 43:14 44:16 45:12
 48:25 50:10 53:9
 54:2 57:9 62:19
 63:13 67:1,4,25
 68:23 74:13
 meaning (2) 35:13
 51:16
 means (3) 11:1 67:17
 71:12
 meant (1) 42:3
 measure (1) 34:24
 medical (18) 3:8 4:21
 4:23 9:14 12:5 29:9
 33:15 35:12 40:11
 48:21 55:18 59:7
 68:8,25 69:24 70:8
 71:19 72:18
 medical-legal (1)
 10:22
 Medicine (2) 14:11
 15:7
 meets (1) 41:2
 member (1) 10:14
 memorize (1) 6:24
 mentioning (1) 41:20
 men's (1) 14:8
 met (2) 24:24 25:3
 metal (1) 72:22
 Michael (2) 1:6 7:24
 mid (1) 45:6
 migrated (1) 10:8
 milligram (1) 41:24
 millimeter (1) 34:22
 mind (4) 11:14 19:18
 19:21 65:20
 mine (3) 55:9,16 57:2
 miscellaneous (1)
 16:3
 miserable (2) 21:25
 66:7
 miseries (1) 23:9
 misinterpret (1) 69:2
 Monday (1) 13:9
 month (4) 15:3 53:5,8
 53:13
 months (6) 14:13
 19:10 21:22 22:13
 56:22 73:25
 Move (1) 70:9
 Moving (2) 33:23 36:2
 mucosa (2) 36:21,22
 multiple (3) 14:6 19:1
 69:7
 muscle (1) 50:1
 M.D (9) 1:6,10 3:2 4:2
 7:24 76:3 77:1,6,12

N

N (2) 2:1 3:13
 name (6) 4:8,17,19
 68:18 76:2 77:15

named (3) 9:16 10:11
 21:17
 names (1) 72:25
 naturally (1) 19:25
 nature (2) 10:2 22:21
 necessarily (1) 25:1
 necessary (1) 38:18
 necrotic (2) 46:13,19
 need (6) 5:21 19:12
 30:21 31:17,19 67:9
 negligence (2) 9:14
 71:19
 negligent (1) 64:12
 neither (2) 71:21 78:8
 neurogenic (1) 14:4
 NeuroUrology (1)
 14:25
 neutral (1) 31:12
 never (9) 17:6 18:22
 22:7 28:25 31:4
 43:6 67:11,12,15
 new (2) 39:16 47:2
 nice (1) 64:1
 nine (1) 12:22
 Ninth (2) 3:21,22
 NOTARY (1) 77:22
 note (9) 8:5 24:13
 34:2 36:11 37:14
 39:23 41:6,18 56:25
 noted (3) 14:9 16:3
 77:3
 notes (19) 2:12 7:16
 7:16 8:18,19,20,21
 8:23 9:1 26:17 27:5
 31:15,15 41:3,4
 42:22 50:6,12 55:18
 November (4) 8:3
 43:21 52:21 53:9
 number (5) 2:11
 18:25 21:22 69:4
 71:1
 numbered (1) 3:4
 nurse (2) 32:13,17

O

oath (1) 77:13
 object (3) 18:16 26:13
 31:21
 objection (5) 17:25
 57:12 59:21 70:1,9
 obligations (1) 13:9
 obtain (1) 16:9
 obtained (1) 25:18
 obviously (11) 5:7
 29:18 31:5 32:13
 40:19,23 47:12
 59:11 62:19 63:4
 72:16
 occasion (1) 4:24
 occasions (1) 5:1
 occurred (6) 19:23
 23:25 41:2 48:23
 60:15 61:25
 occurs (1) 47:22
 October (7) 39:7,10

39:24 40:2 48:23
 50:13 53:11
 office (11) 7:23 16:12
 16:16,18 24:10
 29:12 31:14 41:3
 50:12,21 77:19
 Oh (2) 17:23 33:16
 Ohio (5) 1:2 3:10,17
 3:23 10:17
 Okay (74) 5:5,18,25
 6:10,15 7:18 8:10
 8:15 9:12 10:16
 12:18,21 13:1,13,24
 14:9 15:4,14,21
 16:2 17:1,15,19
 18:10 19:16 21:8
 22:19 23:23 24:15
 25:15 27:17 28:1,5
 34:15 35:8,12 36:2
 36:13,14,15 37:15
 37:22 38:9 39:15
 40:1 43:19 44:23
 46:4,21 47:7 48:20
 50:12 54:17 55:22
 56:3,4 58:24 59:10
 59:18,19 61:17
 63:10,24 66:9 68:21
 70:7,14,23 71:4,15
 72:1 73:14 74:4,24
 old (1) 44:11
 once (9) 7:5 10:24,25
 17:5,7 44:25 52:22
 59:3 63:24
 ones (1) 15:2
 one-page (1) 24:13
 Ontario (1) 3:16
 op (1) 60:19
 open (1) 48:14
 opened (1) 40:8
 opening (1) 40:22
 operate (3) 13:10
 21:24 41:25
 operated (1) 64:22
 operation (3) 22:2
 32:18 39:7
 operations (1) 67:23
 operative (7) 27:4
 34:2 36:11 37:7,11
 37:13 39:23
 opinion (8) 7:7,10
 11:24 30:17 40:10
 45:3 48:20 70:12
 opinions (7) 4:15
 23:24 26:3,7,18
 30:6 59:17
 opportunity (2) 26:6
 59:12
 opposed (1) 49:17
 opted (1) 49:16
 optimal (1) 22:8
 options (2) 28:20
 30:14
 ORAL (2) 1:9 3:1
 order (1) 8:8
 organ (1) 39:4

organized (1) 27:20
 orifice (1) 48:8
 originals (2) 9:7,9
 outcome (1) 12:17
 outpatient (1) 7:24
 overall (1) 12:16
 overlap (3) 62:11,17
 63:6
 overlapping (2) 61:22
 64:10
 overlaps (1) 62:10
 O'Brien (33) 3:20 6:7
 6:11,14,23 8:12 9:6
 10:13 17:25 24:6
 26:7,12 27:14 31:21
 37:19 49:4,11 50:19
 57:12 58:6 59:12,20
 64:1 69:14,18 70:1
 70:9 73:20 74:6,10
 74:11,19 75:1

P

P (2) 3:13,13
 page (25) 2:3,11 8:5
 16:3 28:2 33:24,24
 36:3 37:8 39:19
 41:5 43:19,19 44:24
 46:9 50:24 56:4,8
 58:13 60:11,17
 61:17,18,18 64:3
 pager (1) 5:23
 pages (3) 7:15 8:5,19
 PAGE/LINE (1) 76:4
 paid (1) 74:7
 pain (2) 12:9 47:13
 paragraph (1) 57:5
 parents (2) 53:3,16
 Parkinson's (1) 14:7
 part (7) 20:23 23:13
 30:5 33:22 35:7
 56:22 73:13
 partially (1) 69:20
 participant (1) 14:18
 participate (1) 33:10
 particular (10) 15:23
 17:9 46:4,7,18,22
 49:23 61:2,7 73:13
 particularly (1) 64:13
 parties (1) 78:10
 party (1) 58:7
 pass (3) 48:11 69:8
 69:11
 passed (1) 69:10
 patient (23) 10:10
 11:17 12:3 19:12
 21:3 23:15,16 25:23
 27:8 28:25 31:2,6
 31:17,20 32:14 38:3
 43:15 49:23 54:14
 54:24 61:3 64:18
 67:21
 patients (9) 13:9,12
 14:5 29:1 33:2 54:6
 58:11 61:8 72:22
 peer (1) 14:20

pelvic (4) 12:8 14:11
 15:8 38:25
 pending (1) 4:11
 people (28) 11:8,9
 14:20 22:6,11,16
 27:11 28:12 33:8
 41:25 43:5,8 45:17
 45:20 51:19,19
 57:22,24 58:4,10
 61:6,6 65:21 67:12
 67:25 71:1,5 72:21
 percent (5) 13:6,8
 14:8,8 35:13
 percentage (2) 11:15
 13:3
 Perfect (1) 74:25
 perfectly (1) 14:17
 perform (1) 20:20
 performed (3) 19:7
 49:3 60:22
 period (2) 57:11
 71:22
 person (10) 20:25
 21:2 39:2 44:10
 47:11,13 51:25 52:2
 66:16 77:15
 personal (1) 70:10
 personally (2) 69:13
 77:12
 perspective (1) 21:10
 Philippe (9) 1:10 3:1
 4:2,19 66:23 76:3
 77:1,6,12
 phone (3) 3:17,23
 26:3
 phrase (1) 7:19
 physically (1) 62:16
 physician (7) 7:9
 20:23 21:17 23:14
 27:7 32:18 38:23
 physicians (2) 29:2
 69:23
 pick (1) 36:12
 pieces (1) 59:5
 place (7) 5:7 7:17
 8:16 10:5 40:7,8,17
 PLAINTIFFS (2) 3:3
 3:14
 planes (1) 62:18
 PLEAS (1) 1:1
 please (1) 26:20
 pneumonia (2) 67:8,9
 point (4) 12:14 30:19
 44:3 53:2
 pointed (1) 54:20
 pointing (2) 24:6,7
 portion (1) 45:6
 possibility (1) 60:6
 possible (1) 8:25
 possibly (1) 71:18
 post (1) 13:19
 posterior (1) 45:8
 potentially (1) 66:8
 practice (5) 13:4
 31:24 61:7 71:7

73:24
 pray (1) 35:24
 predicated (1) 30:7
 Prednisone (1) 41:24
 preferable (1) 49:22
 preferred (1) 58:18
 Preliminary (2) 2:5
 4:1
 preoperatively (1)
 46:22
 Prepare (1) 74:5
 prepared (1) 17:8
 preparing (1) 73:2
 present (2) 40:23
 58:12
 presentation (1) 28:9
 pressuring (2) 37:25
 38:2
 pretty (5) 5:11 7:6
 41:8,24 44:11
 prevalent (1) 58:9
 prevent (1) 43:1
 prevented (1) 48:8
 previous (1) 56:8
 previously (3) 10:12
 46:12,12
 pre-existing (1) 12:11
 primarily (1) 18:5
 primary (2) 13:24
 36:19
 principle (8) 18:8
 21:13,14 57:21,22
 57:25 71:8,11
 principles (13) 18:17
 64:23 65:4,6,8,12
 65:20 67:14,16 68:2
 70:24 71:3 73:12
 prior (4) 22:12 31:2
 40:3 49:24
 privilege (1) 21:18
 probability (2) 40:11
 48:21
 probably (28) 6:25
 7:12 11:2 13:5,7
 14:7 16:11,21 18:22
 19:8,13 20:24 23:19
 27:23 33:21 39:8
 40:24 42:10 44:9,9
 48:4 52:19 53:18
 63:24 65:17,21,22
 69:19
 problem (24) 9:3
 12:11 14:1,2 27:6
 27:10 29:3 41:13
 43:3 48:5,10,13,19
 50:3 52:18 58:20
 60:25 61:1 62:7
 63:8 65:17 66:4,6
 67:12
 problems (5) 41:10
 60:19,20 67:10
 72:12
 procedure (16) 3:10
 19:11 21:7 31:3
 36:6,15 43:6 46:7

46:11,22 48:24 49:1
 49:2,7 62:5 67:22
 procedures (1) 27:4
 proceed (1) 32:10
 Proceedings (3) 2:5
 4:1 75:2
 process (2) 23:1
 44:15
 produced (3) 3:2 16:7
 17:10
 professional (3) 4:18
 5:20 6:2
 professor (1) 4:20
 program (6) 16:7
 17:10,11 70:17,20
 73:5
 prolapse (2) 12:8
 14:2
 proper (2) 21:2 23:5
 properly (3) 21:4
 35:20 47:15
 properties (1) 43:13
 property (1) 17:4
 proved (1) 77:13
 provide (2) 16:20
 35:18
 provided (3) 6:6 7:21
 29:10
 provisions (1) 3:11
 proximity (1) 48:18
 PUBLIC (1) 77:22
 publications (1)
 15:19
 published (4) 14:21
 15:9,23 65:7
 pull (3) 27:25 51:6,6
 pulled (2) 50:13 53:23
 pulling (1) 55:2
 pulls (1) 51:3
 purpose (2) 4:14 18:5
 purposes (2) 34:8
 77:18
 purse (14) 61:19,20
 62:1,2,7,8,10,12,15
 62:20,24,24 63:4,22
 pursuant (1) 3:9
 put (14) 17:16 19:2
 23:9,15 34:12 35:1
 35:19 37:3,25 50:8
 54:18 59:21 60:2
 62:20
 putting (2) 10:7 59:23
 P-H-I-L-I-P-P-E (1)
 4:19
 p.m (6) 2:7,7 3:5,5
 5:19 75:2

Q

qualifications (2)
 28:22 29:19
 quality (1) 23:13
 quantitate (1) 44:20
 question (37) 6:4
 11:8 15:12 17:9
 18:15 19:3,16,20

20:5,6,14 21:15
 23:24 24:16 28:5,6
 29:4 31:22 34:9
 36:3,4 37:13 41:15
 47:5 49:5,16 51:1
 51:14 57:7,16 64:8
 65:1 66:10 67:3
 69:7,12 70:18
 questioning (1) 64:4
 questions (12) 4:5
 5:9 13:16 21:9
 26:19 29:22 33:23
 34:1 51:2 57:19
 60:4 69:4
 quickly (1) 44:12
 quiet (1) 55:1
 quite (1) 26:13
 quote (1) 41:7

R

R (1) 3:13
 radiation (1) 23:3
 raise (1) 47:16
 randomized (1) 18:20
 reach (1) 30:23
 reactive (1) 45:21
 read (18) 18:23 24:18
 24:22 30:2 31:4
 35:4 36:7,10,11,13
 38:22 55:15 56:11
 57:8 59:15,22 65:1
 77:1
 reading (7) 13:18,22
 39:22,23 50:5 55:19
 57:6
 reality (1) 34:18
 realize (2) 17:8 72:2
 realizes (1) 40:22
 realizing (1) 21:25
 really (19) 6:7 11:8
 13:13 18:11 19:21
 27:15 29:5 33:21
 34:24 36:12 42:10
 43:10 48:10 50:9
 52:2 57:10 61:11
 64:22,22
 reason (9) 23:4,8
 27:16 42:8 43:4
 47:5 56:23 60:9
 76:4
 reasonable (4) 7:1
 35:6 40:10 48:21
 reasons (2) 20:2 39:1
 recall (12) 10:19 12:1
 12:14 28:16 29:24
 30:10 34:19 35:20
 39:12 49:24 52:21
 55:19
 receive (2) 6:12 11:18
 received (4) 8:12 21:2
 24:3,21
 recer (1) 12:21
 recertification (1)
 12:25
 recertified (1) 12:22

recheck (1) 34:12
 recipe (3) 65:10 66:22
 66:24
 recognize (1) 66:6
 recollection (4) 10:1
 12:6 15:5 53:4
 record (8) 3:11 4:17
 33:20 50:21 59:21
 66:11 78:6,12
 records (9) 7:23,25
 17:3 27:3 29:9,11
 29:17 37:11 59:7
 rectus (1) 50:1
 recurred (1) 53:14
 recurrent (1) 64:25
 reddition (1) 52:16
 reduce (1) 67:7
 refer (1) 29:8
 referrals (1) 19:14
 referring (1) 62:4
 refers (1) 65:20
 reflect (3) 29:12 31:15
 31:16
 reform (2) 69:24 70:8
 reinforcing (1) 62:18
 related (1) 78:9
 relationship (3) 27:7
 32:1 55:21
 relative (6) 7:8 9:23
 15:9 20:11 44:25
 78:11
 relatively (1) 41:9
 remain (1) 31:11
 remember (15) 8:8
 10:3 12:15,17 26:21
 34:11 39:9,21,23
 46:5,6 52:25 54:1
 55:19 69:5
 remove (2) 54:3,4
 render (1) 25:23
 rendered (1) 10:16
 rendition (1) 26:18
 reoccur (1) 54:6
 reopened (1) 40:25
 reopening (1) 51:24
 reoperate (1) 50:11
 repair (62) 12:8 17:22
 19:7,13,17 20:9,13
 20:15 21:13,14
 22:20 29:15,21 31:9
 31:18 36:7 37:9
 38:5,12,20 39:14
 40:18,18 43:16,23
 44:2 46:4,18 48:22
 50:7 51:13,24 53:11
 53:12,22 54:8,10,25
 57:11,21 61:4,13
 63:1 64:13,21,24
 65:4,8,13,15,24
 66:21,24 67:17
 70:25 71:5,18,22
 72:3,9,19 73:10
 repaired (5) 21:6
 22:10 23:8 40:7
 45:5

repairing (4) 19:22
 35:5 41:8 43:17
 repairs (13) 16:6
 20:21 21:1,5,11
 22:12 27:12 28:15
 52:10 56:15,16,20
 61:8
 rephrase (1) 30:4
 report (11) 6:16,16
 15:25 18:23 24:8,21
 37:7 45:13 52:6
 55:9 60:19
 reported (3) 1:14 3:6
 35:3
 reporter (3) 9:1 78:5
 78:17
 Reporter's (2) 2:8
 78:3
 represent (1) 4:9
 reputation (1) 7:8
 requests (1) 11:19
 require (1) 33:1
 required (2) 5:2 68:23
 reread (1) 37:13
 research (1) 13:8
 residency (1) 73:5
 resident (3) 9:16,19
 9:25
 residents (5) 11:4
 66:12,13 68:3 70:16
 resolution (1) 27:6
 resolved (1) 41:22
 resolving (1) 30:22
 response (1) 56:20
 responsibilities (1)
 5:20
 responsible (1) 66:17
 rest (1) 58:21
 restrictions (1) 54:18
 result (1) 22:4
 results (1) 52:15
 retained (2) 4:9 6:20
 retrograde (1) 60:23
 reverify (1) 39:24
 review (10) 5:5 7:15
 10:22 11:23 14:22
 15:2,3,24 27:3
 35:14
 reviewed (5) 8:6,22
 8:24 14:20 26:4
 reviewing (2) 11:10
 33:8
 right (37) 5:1,16,17
 6:20 7:2,7 9:23
 10:12 11:7 13:3
 14:12 17:17 20:17
 21:8 27:17 28:14
 30:4 34:7,10 36:2
 37:23 42:15,18,19
 48:9 50:1 51:1 53:8
 55:17 59:1,10 60:1
 61:21 62:12 66:10
 66:16 73:14
 risk (3) 31:7 51:21
 52:17

ROETZEL (1) 3:21
 Roger (2) 21:17,19
 room (1) 9:4
 rotated (1) 14:14
 roughly (1) 44:1
 rule (1) 23:22
 rules (2) 3:10 5:6
 run (1) 25:10
 ruptured (1) 10:4

S

S (1) 3:13
 safely (1) 5:18
 sake (1) 20:13
 San (4) 53:2,15 54:24
 55:11
 satisfactory (1) 50:7
 saw (3) 19:12 31:7
 40:5
 saying (5) 35:9,24
 38:10 64:5,7
 says (10) 30:16 31:1
 34:3,6 36:22 41:7,7
 41:8 43:23 56:12
 scar (1) 56:19
 scars (1) 49:24
 scenario (1) 40:14
 scheduled (1) 22:14
 scientific (1) 72:5
 sclerosis (1) 14:6
 scope (1) 47:17
 seal (1) 77:19
 second (8) 9:21 40:12
 45:1 46:4 48:22
 53:11 62:20 63:22
 secondary (2) 41:10
 41:13
 seconds (1) 5:16
 section (1) 73:9
 see (35) 7:11 13:9
 14:5 15:17 22:11
 23:7 25:24 26:23
 27:1 28:13 34:4
 38:12,14 40:18 45:4
 46:15,16,20 47:9,18
 51:7 53:3,15 54:9
 59:8 60:8,21 63:6,8
 65:16 67:25 70:14
 72:8,11,13
 seeing (1) 13:12
 seen (6) 24:11 40:14
 40:21 59:22 67:11
 67:12
 sees (1) 47:2
 send (1) 35:23
 sense (4) 35:2 36:1
 45:12 55:5
 sensing (1) 5:12
 sent (1) 7:15
 serosa (1) 37:2
 served (1) 4:23
 serving (1) 4:13
 set (2) 9:4 67:13
 setting (3) 24:23
 66:17,18

seven (4) 19:9 70:20
 74:13,17
 share (1) 26:6
 shirt (1) 63:2
 short (2) 5:15 72:11
 shorthand (3) 3:7
 78:4,17
 shown (1) 67:15
 shows (1) 32:2
 sic (1) 16:6
 side (4) 7:22 10:9
 48:9 50:2
 sign (1) 32:11
 signature (2) 76:1
 77:2
 signed (2) 31:9 32:12
 simpler (1) 30:5
 sit (1) 28:7
 site (1) 22:22
 sitting (1) 7:11
 situation (6) 11:24
 20:19 28:18 45:1
 60:15 61:2
 six (2) 19:9 39:5
 Sixth (1) 3:16
 size (4) 34:1,24 35:20
 66:1
 skip (1) 28:14
 Skipping (1) 61:17
 slave (1) 72:21
 slaves (1) 72:23
 small (3) 34:5 35:1
 66:7
 smaller (2) 34:22,22
 SMITH (1) 3:15
 someplace (1) 55:25
 somewhat (1) 27:20
 soon (2) 22:14 58:4
 sorry (3) 36:23 60:11
 71:10
 sort (3) 47:9 65:18
 66:9
 Southwestern (2) 3:8
 4:21
 speak (3) 7:5 19:3
 24:23
 specialist (1) 22:8
 specialized (1) 19:14
 specific (2) 4:16
 68:18
 specifically (1) 54:2
 specifics (1) 26:20
 spend (1) 13:4
 spent (2) 32:7 73:14
 spinal (1) 14:6
 spraying (1) 52:23
 stack (1) 7:20
 stage (1) 52:20
 standard (16) 17:21
 18:1,4,12 19:4 25:2
 27:2 31:19 35:12
 38:9,10 49:12 50:15
 61:15 64:11 72:14
 standards (8) 24:24
 25:4 30:24,25 32:25

33:17,18 38:11
 stands (1) 16:23
 start (4) 5:7 8:16 36:5
 71:24
 started (2) 21:16 53:7
 starting (1) 44:24
 starts (1) 53:9
 state (11) 3:6 4:17
 10:17 17:19 25:5
 33:18 77:8,23 78:1
 78:5,18
 stated (3) 3:11 34:5
 34:21
 stayed (1) 39:5
 stem (1) 26:3
 stent (2) 10:7 48:11
 step (3) 27:3,4 38:6
 steroid (1) 43:1
 steroids (10) 41:11
 41:14,17,20 42:9,11
 42:16,20 43:9,12
 stopped (1) 43:17
 straight (1) 50:20
 straightforward (2)
 41:9 60:4
 strange (1) 8:16
 Street (2) 3:16,21
 stretching (2) 51:24
 52:17
 strike (1) 70:10
 string (13) 61:19,20
 62:1,2,8,8,12,15,20
 62:24,25 63:4,23
 strings (1) 62:11
 strong (1) 71:11
 students (2) 66:19,20
 submissions (2)
 14:20,22
 subscribed (2) 77:16
 78:14
 successes (1) 67:24
 successful (2) 22:3
 25:25
 successfully (1) 73:4
 sufficient (1) 32:10
 suggested (1) 45:20
 summarize (1) 60:18
 summary (1) 26:1
 support (1) 61:14
 sure (20) 6:12 13:17
 19:19 24:17 26:19
 29:21 32:1,4,9,21
 38:21 44:16 47:4
 49:4 51:11 55:2
 58:15 62:21 65:19
 74:21
 surgery (19) 10:4
 12:10,13 13:12
 14:11 15:8 19:18
 25:4 28:21 31:6
 41:19 43:25 44:18
 49:17 58:19 59:1
 61:25 64:14 73:25
 surgical (9) 15:9
 29:15 31:17 34:16

36:6,15 37:9 64:21
 65:5
 surgically (1) 21:23
 surprise (2) 32:23
 48:18
 surprised (1) 54:9
 surprising (1) 44:17
 surrounding (1)
 22:22
 suspect (4) 33:14
 45:2 53:16,19
 suspected (1) 41:1
 suspicion (1) 47:16
 suture (4) 37:25
 61:22 62:25 64:10
 sutures (5) 45:7,11
 45:15,21 56:8
 swelling (3) 48:7,16
 48:16
 sworn (3) 3:3 4:3
 78:14
 symptoms (1) 47:9
 system (2) 28:13
 42:13

T

table (1) 24:23
 take (14) 19:1 30:11
 31:18 32:6 34:8
 43:9 52:11 54:15
 59:12,14 68:10,16
 68:24 70:15
 taken (3) 3:3 30:12
 78:11
 talk (3) 30:1 43:21
 56:12
 talked (1) 54:11
 talking (2) 20:14
 74:20
 tapered (1) 41:23
 taught (2) 65:15
 70:24
 Taylor-Kolis (30) 2:6
 3:15 4:5 6:15 9:12
 18:10 24:15,20
 26:24 27:17 32:24
 37:20 49:10,14,19
 50:22,23 57:17 60:1
 60:10 69:16,19,21
 70:7,14 73:18,21
 74:4,16,24
 teach (2) 66:18 71:2
 teaching (1) 13:8
 technique (2) 36:17
 65:5
 techniques (2) 15:10
 37:9
 tell (11) 15:22 31:20
 33:5 42:7,24 54:6
 54:23,25 65:13
 66:23 72:17
 tempted (1) 50:2
 ten (6) 9:22 10:24
 13:2 15:3 65:21
 70:21

tend (1) 61:9
 term (2) 18:1 73:11
 terms (3) 5:13 65:4
 74:11
 terribly (1) 21:10
 test (2) 52:16 69:9
 testified (7) 4:3 30:8,9
 46:7 56:1 57:18
 68:22
 testify (1) 5:2
 testimony (12) 10:17
 11:15 12:2 30:13
 39:16 44:24 46:17
 57:14 58:17 69:22
 78:7,11
 tests (1) 68:10
 Texas (9) 3:6,7,9
 68:11,20,25 78:1,5
 78:18
 thank (3) 57:6 74:5
 75:1
 thing (10) 11:6 23:5
 28:1 29:25 41:18
 60:16 61:16 66:2
 68:8 71:17
 things (10) 6:25 7:16
 8:8 27:21 47:16
 48:13 54:21 59:14
 67:25 72:6
 think (75) 8:18 13:1
 14:15 15:6 16:16
 18:19 20:22 21:3,5
 22:15 23:5,6,10,18
 24:8 26:16,25 27:13
 29:16,23 30:2,17
 31:10,11,23,25
 32:21 33:3 34:3,13
 35:4,25 38:8,11
 39:3,21,22 40:3,6
 40:15,21 42:6,9,25
 43:11,17 44:12,19
 45:9,22,24 46:25
 48:12 49:5 50:9,15
 50:19 51:18,25 52:4
 52:11,14 56:14 58:6
 58:22 60:3,5 61:2
 63:22 64:6,13,19
 68:9 69:6 72:2
 thinking (2) 32:8 45:7
 thinks (2) 49:6 60:9
 third (1) 49:3
 thought (2) 24:8
 69:12
 thoughts (2) 5:15
 45:23
 three (6) 27:12 34:22
 46:8 56:22 66:25
 72:13
 throw (1) 62:25
 thumb (1) 23:22
 Thursday (1) 13:10
 tie (1) 45:18
 tied (1) 45:18
 tight (1) 45:19
 time (46) 6:2 10:1

11:20 12:1 13:3,14
17:21 19:6 22:8
25:9 27:14 32:8
38:12,19 40:20,23
41:10 43:5,18 44:3
44:8 45:3 46:1,17
46:21 47:17,22 49:3
49:17 50:14 52:12
53:22,22 56:10
57:11 58:8 65:24
68:1 70:3,6,25
71:24 72:11 73:14
74:2,5
timely (1) 25:21
times (3) 11:2 22:11
72:21
timing (5) 22:15,20
23:12 53:14 57:20
tired (2) 16:22 17:24
tissue (16) 22:21
36:21,23,24,25
46:12,14,19 48:15
48:16 56:19 61:23
63:5,11,20 64:21
tissues (8) 23:13,18
44:3,7,11,18 63:17
67:13
today (3) 19:3 28:2,7
told (4) 26:6 31:2
54:12,14
tomorrow (4) 22:9
43:15 74:9,10
tonight (1) 74:9
tool (1) 17:12
top (5) 40:16 50:8
61:21 62:3,19
topic (2) 15:18 72:3
tort (2) 69:24 70:8
totally (1) 37:14
tract (1) 60:21
tracts (1) 61:5
train (4) 11:5,5 21:18
65:12
trained (3) 24:25
38:23 52:9
training (6) 9:16 21:3
52:11 66:12 67:19
72:7
transcript (4) 9:8
74:14,21 78:6
transpired (1) 29:5
transpires (1) 52:5
travel (4) 11:5 54:7
55:4,7
treated (1) 72:23
treatment (4) 13:20
13:25 64:15,17
tremendous (1) 59:24
tremendously (1)
33:4
trial (7) 5:3 9:17 69:22
73:22 74:15,18,23
trials (1) 18:20
tried (4) 21:24 35:19
37:3 65:25

tries (1) 67:20
trigone (1) 47:24
trip (2) 33:5 54:15
trips (1) 26:15
true (3) 44:9 77:3 78:6
trust (1) 31:25
trusting (1) 32:6
truth (1) 18:11
try (6) 5:13 22:16 57:2
63:17,18 71:5
trying (10) 26:25
27:14 32:20 45:24
60:2 62:22 63:22
64:15 66:4 67:6
tube (1) 47:14
Tuesday (1) 13:10
tugging (1) 55:3
turned (1) 5:23
two (11) 7:15 8:5,19
38:2 47:25 49:24
65:12 67:11,12 69:5
72:12
two-page (1) 8:5
type (6) 18:4 54:8
55:21 61:16 67:10
71:6
types (2) 19:15 47:15

U

UAU (1) 16:6
UCLA (3) 9:15,19,24
ultimately (7) 25:23
27:10 48:5,12 49:2
49:7 72:10
unable (1) 34:4
unavailable (1) 73:22
uncontrollably (1)
52:23
underlying (1) 56:17
understand (10)
19:19 21:4 27:15
45:24 49:5 58:16,16
62:21 68:24 71:23
understanding (4)
4:12 62:23 63:7
73:15
undertake (2) 31:9
64:20
underwent (1) 12:7
unfolded (1) 27:5
unfortunate (1) 25:22
unfortunately (2)
65:16 67:6
university (10) 3:7 6:5
6:9 9:22 11:22
33:13,19 68:16,23
70:21
unpleasant (1) 22:17
upper (2) 60:21 61:5
ureter (2) 48:6,17
ureteric (3) 10:5,6
48:8
ureterogram (1)
60:23
Ureterovaginal (1)

16:5
ureters (15) 38:13,15
38:17,19,25 46:24
47:6,8,21,24,25
48:2,3,6 61:3
urine (3) 23:20 39:11
47:18
Urodynamics (1)
14:25
urological (2) 14:3
16:24
urologist (2) 21:11,19
urologists (2) 18:6
20:8
urology (12) 3:8 4:21
12:19 13:4 14:23,24
14:24,25 25:10
66:13,18 73:6
use (2) 7:19 18:1
usually (15) 11:25
34:21 36:25 47:16
47:19,23 48:1 51:6
51:7,8 56:15,16
58:4 63:16,19
UT (1) 4:21

V

vagina (8) 19:24 22:3
37:3 40:16 47:4,11
50:5 63:15
vaginal (6) 17:24
36:22 37:5 45:6
61:20 62:3
vaginally (2) 49:18,22
vague (3) 18:14 34:23
53:4
varied (1) 13:11
varies (3) 11:3 33:4,7
verbally (1) 5:9
verbatim (1) 60:12
verify (1) 37:12
versus (1) 11:17
vesico-vaginal (6)
15:10 16:5 19:17
20:17 66:21 70:25
vesico-virg (1) 17:23
video (3) 1:9 3:1,5,11
videotaping (1) 73:16
view (1) 61:1
virginal (1) 17:23
visible (1) 40:9
visit (1) 53:23
visual (1) 17:11
vitae (1) 16:3
voice (1) 5:13
voiding (1) 14:3
Volume (3) 7:25,25
7:25
VS (1) 1:5

W

wait (9) 8:17 21:21
23:4,17 56:16,22
57:10 58:9,25
waiting (1) 64:14

waive (1) 74:12
waiver (2) 74:11,17
wall (4) 37:1 45:8,11
45:15
want (23) 6:22 12:4
13:15 19:9 23:4
26:18 27:20 28:1
31:13 35:8 40:13
50:10 51:7 52:2
56:10,22 57:15
58:15,25 59:15 60:7
60:19 61:11
wanted (3) 24:16
25:15 36:5
wants (2) 22:10 67:21
wasn't (3) 44:13 49:9
53:8
water (1) 40:5
watertight (1) 38:5
way (29) 4:8 7:9 9:10
10:17 11:12 17:19
18:19 19:20 20:5
24:17 25:5,16 27:5
32:3,12 34:25 44:7
46:25 55:10 57:18
64:5 65:10,11,13,14
66:5 67:5 68:3,4
ways (1) 72:6
Wednesday (1) 13:11
week (4) 13:10,11
44:1,1
weeks (4) 6:22,25
19:11 43:24
welcome (1) 70:11
went (9) 9:17 26:9,11
27:3 46:18 53:2,2
53:16 58:25
weren't (1) 30:14
we'll (14) 9:7,10 20:12
20:13,18 25:19
26:22,23 28:2 38:12
45:25 73:16 74:13
74:22
we're (10) 20:14
22:15 27:18 28:13
34:23 36:4 56:12
60:10 64:6 67:15
we've (3) 22:7 62:1
74:12
whatsoever (1) 32:19
when's (1) 22:8
wider (1) 62:15
wife (1) 13:6
wish (4) 68:1 70:5
71:25 73:5
witness (6) 3:2 4:13
10:18 24:12 70:5
76:2
woman (2) 12:7 28:18
women (4) 14:1,3
21:20,24
women's (1) 14:8
wonder (1) 47:19
wonderful (1) 67:24
word (1) 71:12

words (1) 62:24
work (6) 25:8 27:23
49:22 55:7 60:13
67:21
worked (1) 10:13
working (1) 29:19
worried (2) 42:2
47:20
wouldn't (6) 33:6
35:10,16 42:15
54:14,16
write (1) 32:8
writing (1) 59:9
written (5) 8:20 17:12
17:14 27:19 73:3
wrong (3) 60:12 71:13
71:17
wrongly (1) 16:23
wrote (4) 17:20 25:14
25:16 41:6

X

X (1) 2:1

Y

yeah (16) 18:3 21:15
24:12 31:23 39:8
43:24 50:22,23
52:25 58:5,22 62:7
66:22 69:16 74:20
74:22
year (8) 10:25 11:2
19:8,9 68:10,18
69:4,25
years (18) 9:22 10:25
12:4,22 13:2 15:7
16:13 18:25 33:7
44:11 58:2 69:5,25
70:19,20,21,22
72:13
Yep (1) 16:14
yesterday (1) 19:12
young (1) 44:10

Z

Zimmern (14) 1:10
3:2 4:2,20 9:13 19:6
57:13,17 60:8 68:24
76:3 77:1,6,12
Zimmern's (1) 66:23
Z-I-M-M-E-R-N (1)
4:20

#

#57036 (2) 1:14 77:7

1

1 (3) 2:12 7:25 9:11
10 (3) 18:24 33:25
36:9
10/9 (1) 49:8
11 (3) 1:11 3:4 76:3
11/7 (2) 49:7 53:12
12/31/2007 (1) 78:19

13 (1) 44:25
13700 (1) 3:16
1375 (1) 3:21
14 (2) 33:25 60:17
15 (4) 18:24 39:20
50:25 64:4
16 (2) 16:13 70:18
17 (2) 36:13 70:22
17th (1) 78:14
1970s (1) 21:17
1990 (1) 16:7

2

2 (2) 7:25 8:2
20 (5) 18:24 36:9,13
43:23 50:25
200 (1) 13:6
2005 (3) 8:3,3 24:13
2005-CV564503 (1)
1:3
2006 (5) 1:11 3:4 6:17
76:3 78:15
21 (1) 58:13
216-621-0070 (1) 3:17
216-621-4008 (1) 3:18
216-623-0134 (1) 3:24
216-696-7767 (1) 3:23
23 (4) 60:11,17 61:18
61:19
24th (2) 50:13 73:17
25 (7) 28:2 43:23 58:1
58:14 60:17 64:3,4
27th (5) 6:17 51:3,15
53:9 56:9
28 (1) 24:13

3

3 (5) 2:4 7:25,25,25
8:1
3rd (3) 52:22 53:10
56:10
38 (2) 33:24,24

4

4 (3) 2:5,6 8:3
40 (1) 14:8
44113-1704 (1) 3:17
44114 (1) 3:23
46 (1) 36:3

5

5th (1) 61:12
50 (1) 44:11
51 (2) 35:13 39:19
5178 (1) 78:19
52 (2) 41:5 43:19
5323 (1) 3:9
54 (1) 44:24
56 (1) 46:9

6

6th (2) 39:10 61:13
60 (1) 14:7
62 (1) 50:24

66 (1) 56:4
67 (1) 58:13

7

7th (1) 61:13
7:00 (1) 3:5
7:01 (1) 2:7
76 (1) 2:8

8

8 (1) 39:19
8:00 (1) 5:19
8:30 (3) 2:7 3:5 75:2
80 (1) 13:7

9

9 (5) 2:12 16:3 39:7
39:24 53:11
9th (2) 40:2 48:23
9/25 (1) 41:20
9/25/03 (1) 37:17
9/30 (3) 37:19,22
60:15
9/30/03 (2) 37:22 62:4

